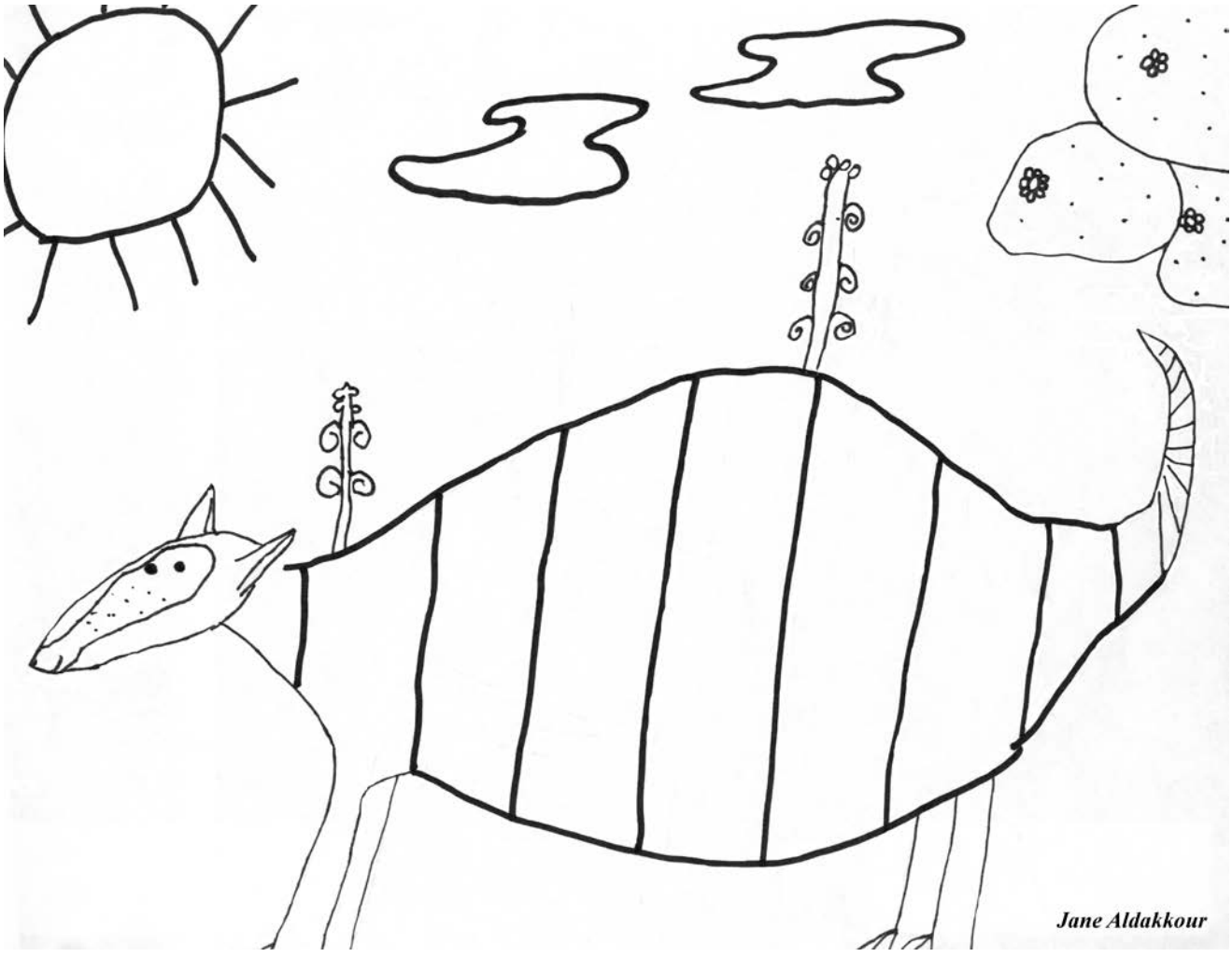
TEXAS REGISTER

Volume 38 Number 7 *February 15, 2013* *Pages 721 - 1062*



School children's artwork is used to decorate the front cover and blank filler pages of the *Texas Register*. Teachers throughout the state submit the drawings for students in grades K-12. The drawings dress up the otherwise gray pages of the *Texas Register* and introduce students to this obscure but important facet of state government.

The artwork featured on the front cover is chosen at random. Inside each issue, the artwork is published on what would otherwise be blank pages in the *Texas Register*. These blank pages are caused by the production process used to print the *Texas Register*.

Texas Register, **(ISSN 0362-4781, USPS 120-090),** is published weekly (52 times per year) for $211.00 ($311.00 for first class mail delivery) by LexisNexis Matthew Bender & Co., Inc., 1275 Broadway, Albany, N.Y. 12204-2694.

The ***Texas Register*** is published under the Government Code, Title 10, Chapter 2002. Periodicals Postage Paid at Albany, N.Y. and at additional mailing offices.

POSTMASTER: Send address changes to the ***Texas Register,*** 136 Carlin Rd., Conklin, N.Y. 13748-1531.

a section of the
Office of the Secretary of State
P.O. Box 13824
Austin, TX 78711-3824
(512) 463-5561
FAX (512) 463-5569

http://www.sos.state.tx.us
register@sos.state.tx.us

IN THIS ISSUE

ADOPTED RULES

RULE REVIEW

Proposed Rule Reviews

Adopted Rule Reviews

TABLES AND GRAPHICS

IN ADDITION

Office of the Attorney General

Comptroller of Public Accounts

Office of Consumer Credit Commissioner

Texas Commission on Environmental Quality

Texas Ethics Commission

Texas Facilities Commission

Department of State Health Services

Texas Department of Insurance

Texas Lottery Commission

Texas Low-Level Radioactive Waste Disposal Compact Commission

North Central Texas Council of Governments

Public Utility Commission of Texas

Texas Department of Transportation

THE GOVERNOR

As required by Government Code, §2002.011(4), the *Texas Register* publishes executive orders issued by the Governor of Texas. Appointments and proclamations are also published. Appointments are published in chronological order. Additional information on documents submitted for publication by the Governor's Office can be obtained by calling (512) 463-1828.

Appointments

Appointments for January 31, 2013

Appointed to the Texas Institute of Health Care Quality and Efficiency Board of Directors for a term to expire January 31, 2017, Joel T. Allison of Dallas (reappointed).

Appointed to the Texas Institute of Health Care Quality and Efficiency Board of Directors for a term to expire January 31, 2017, Robyn M. Jacobson of Richmond (reappointed).

Appointed to the Texas Institute of Health Care Quality and Efficiency Board of Directors for a term to expire January 31, 2017, John C. Joe of Houston (reappointed).

Appointed to the Texas Institute of Health Care Quality and Efficiency Board of Directors for a term to expire January 31, 2017, Beverly B. Nuckols of New Braunfels (reappointed).

Appointed to the Texas Institute of Health Care Quality and Efficiency Board of Directors for a term to expire January 31, 2017, Thomas J. Quirk of Dallas (reappointed).

Appointed to the Texas Institute of Health Care Quality and Efficiency Board of Directors for a term to expire January 31, 2017, Ben G. Raimer of Galveston (reappointed).

Appointed to the Texas Institute of Health Care Quality and Efficiency Board of Directors for a term to expire January 31, 2017, Michael "Shannon" Stansbury of Dallas (reappointed).

Pursuant to HB 1146, 82nd Legislature, Regular Session, appointed to the Appraisal Management Companies Advisory Committee for a term to expire January 31, 2014, Lawrence McNamara of Dallas.

Pursuant to HB 1146, 82nd Legislature, Regular Session, appointed to the Appraisal Management Companies Advisory Committee for a term to expire January 31, 2015, Sara Jones Oates of Austin.

Appointed to the Gulf Coast and Atlantic States Regional Task Force for a term to expire August 26, 2014, Joshua Havens of Austin (reappointed).

Appointed to the Gulf Coast and Atlantic States Regional Task Force for a term to expire August 26, 2014, W. Nim Kidd of San Antonio (reappointed).

Rick Perry, Governor

TRD-201300492

♦ ♦ ♦

Proclamation 41-3314

TO ALL TO WHOM THESE PRESENTS SHALL COME:

I, RICK PERRY, Governor of the State of Texas, issued an Emergency Disaster Proclamation on July 5, 2011, certifying that exceptional drought conditions posed a threat of imminent disaster in specified counties in Texas.

WHEREAS, record high temperatures, preceded by significantly low rainfall, have resulted in declining reservoir and aquifer levels, threatening water supplies and delivery systems in many parts of the state; and

WHEREAS, prolonged dry conditions continue to increase the threat of wildfire across many portions of the state; and

WHEREAS, these drought conditions have reached historic levels and continue to pose an imminent threat to public health, property and the economy; and

WHEREAS, this state of disaster includes the counties of Archer, Armstrong, Atascosa, Austin, Bailey, Bandera, Bastrop, Baylor, Bee, Bell, Blanco, Borden, Bosque, Bowie, Brazoria, Brazos, Briscoe, Brooks, Brown, Burleson, Burnet, Caldwell, Callahan, Cameron, Carson, Castro, Childress, Clay, Cochran, Coke, Collin, Collingsworth, Colorado, Comal, Comanche, Cooke, Coryell, Cottle, Crockett, Crosby, Culberson, Dallam, Dallas, Dawson, Deaf Smith, Delta, Denton, DeWitt, Dickens, Dimmit, Donley, Duval, Eastland, Edwards, Ellis, El Paso, Erath, Falls, Fannin, Fayette, Fisher, Floyd, Foard, Fort Bend, Freestone, Gaines, Garza, Gillespie, Glasscock, Goliad, Gonzales, Gray, Grayson, Grimes, Guadalupe, Hale, Hall, Hamilton, Hansford, Hardeman, Harris, Hartley, Haskell, Hays, Hemphill, Hidalgo, Hill, Hockley, Hood, Hopkins, Howard, Hudspeth, Hunt, Hutchinson, Jack, Jeff Davis, Jim Hogg, Jim Wells, Johnson, Jones, Karnes, Kaufman, Kendall, Kenedy, Kent, Kerr, Kimble, King, Kinney, Kleberg, Knox, LaSalle, Lamar, Lamb, Lampasas, Lee, Leon, Limestone, Lipscomb, Live Oak, Llano, Lubbock, Lynn, Madison, Mason, Maverick, McCulloch, McLennan, McMullen, Menard, Milam, Mills, Mitchell, Montague, Moore, Motley, Navarro, Nolan, Nueces, Ochiltree, Oldham, Palo Pinto, Parker, Parmer, Potter, Presidio, Randall, Real, Red River, Refugio, Roberts, Robertson, Rockwall, San Patricio, San Saba, Schleicher, Scurry, Shackelford, Sherman, Somervell, Starr, Stephens, Sterling, Stonewall, Sutton, Swisher, Tarrant, Taylor, Terry, Throckmorton, Travis, Uvalde, Val Verde, Victoria, Waller, Washington, Webb, Wheeler, Wichita, Wilbarger, Willacy, Williamson, Wise, Yoakum, Young, Zapata and Zavala.

THEREFORE, in accordance with the authority vested in me by Section 418.014 of the Texas Government Code, I do hereby renew the disaster proclamation and direct that all necessary measures, both public and private as authorized under Section 418.017 of the code, be implemented to meet that threat.

As provided in Section 418.016 of the code, all rules and regulations that may inhibit or prevent prompt response to this threat are suspended for the duration of the state of disaster.

In accordance with the statutory requirements, copies of this proclamation shall be filed with the applicable authorities.

IN TESTIMONY WHEREOF, I have hereunto signed my name and have officially caused the Seal of State to be affixed at my office in the City of Austin, Texas, this the 25th day of January, 2013.

Rick Perry, Governor

TRD-201300493

THE ATTORNEY GENERAL

The *Texas Register* publishes summaries of the following: Requests for Opinions, Opinions, Open Records Decisions.

An index to the full text of these documents is available from the Attorney General's Internet site http://www.oag.state.tx.us. Telephone: 512-936-1730. For information about pending requests for opinions, telephone 512-463-2110.

An Attorney General Opinion is a written interpretation of existing law. The Attorney General writes opinions as part of his responsibility to act as legal counsel for the State of Texas. Opinions are written only at the request of certain state officials. The Texas Government Code indicates to whom the Attorney General may provide a legal opinion. He may not write legal opinions for private individuals or for any officials other than those specified by statute. (Listing of authorized requestors: http://www.oag.state.tx.us/opinopen/opinhome.shtml.)

Requests for Opinions

RQ-1106-GA

Requestor:

The Honorable Leticia Van de Putte

Chair, Committee on Veteran Affairs and Military Installations

Texas State Senate

Post Office Box 12068

Austin, Texas 78711-2068

Re: Whether the Qualified Allocation Plan adopted by the Texas Department of Housing and Community Affairs complies with Government Code section 2306.6710 (RQ-1106-GA)

Briefs requested by March 6, 2013

For further information, please access the website at www.oag.state.tx.us or call the Opinion Committee at (512) 463-2110.

TRD-201300459
Katherine Cary
General Counsel
Office of the Attorney General
Filed: February 5, 2013

♦ ♦ ♦

Opinions

Opinion No. GA-0986

Mr. David Slayton

Administrative Director

Office of Court Administration

Post Office Box 12066

Austin, Texas 78711-2066

Re: Whether a prosecutor may require that a defendant enter a guilty plea as a condition for participation in a pretrial diversion program under section 76.011 of the Texas Government Code (RQ-1072-GA)

S U M M A R Y

Due to the lack of controlling legal authority, we cannot advise you whether a prosecutor may require defendants to plead guilty as a condition for pretrial intervention under section 76.011 of the Government Code. It is for the Legislature to provide a more explicit legal framework governing the scope and operation of pretrial diversion in this State.

Opinion No. GA-0987

The Honorable James L. Keffer

Chair, Committee on Energy Resources

Texas House of Representatives

Post Office Box 2910

Austin, Texas 78768-2910

Re: Authority of the Comptroller to implement rules regarding the imposition and collection of a sales and use tax by a municipality under particular circumstances (RQ-1078-GA)

S U M M A R Y

The Comptroller has concluded that, pursuant to Tax Code sections 321.106 and 321.108, voters in areas annexed for limited purposes under Local Government Code section 43.0751 must be given the opportunity to vote on the imposition of fire control and crime control district taxes before a municipality may impose them on those areas. As the agency charged with administration, collection and enforcement of the taxes authorized by chapter 321, the Comptroller's reasonable interpretation would likely be shown deference by the courts.

Opinion No. GA-0988

The Honorable Ruth Jones McClendon

Chair, Committee on Rules and Resolutions

Texas House of Representatives

Post Office Box 2910

Austin, Texas 78768-2910

Re: Whether a county may provide mandatory solid waste disposal services, by contract or otherwise, in an area of the county that is within the extraterritorial jurisdiction of a municipality but that is not receiving such service from the municipality (RQ-1081-GA)

S U M M A R Y

While section 364.034 of the Health and Safety Code authorizes a county to provide mandatory solid waste disposal services in its territory, section 364.011 limits that authority by denying a county authority to regulate in a municipality's ETJ.

Section 364.031 of the Health and Safety Code authorizes cooperative agreements between a municipality and a county that would permit

the county to provide mandatory solid waste disposal services in an area of the county that is within the extraterritorial jurisdiction of the municipality that is not receiving such services from the municipality.

For further information, please access the website at www.oag.state.tx.us or call the Opinion Committee at (512) 463-2110.

TRD-201300476

Katherine Cary
General Counsel
Office of the Attorney General
Filed: February 6, 2013

♦ ♦ ♦

TEXAS ETHICS COMMISSION

The Texas Ethics Commission is authorized by the Government Code, §571.091, to issue advisory opinions in regard to the following statutes: the Government Code, Chapter 302; the Government Code, Chapter 305; the Government Code, Chapter 572; the Election Code, Title 15; the Penal Code, Chapter 36; and the Penal Code, Chapter 39.

Requests for copies of the full text of opinions or questions on particular submissions should be addressed to the Office of the Texas Ethics Commission, P.O. Box 12070, Austin, Texas 78711-2070, (512) 463-5800.

Ethics Advisory Opinions

EAO-508. The Texas Ethics Commission has been asked to consider whether a legislator may receive compensation as the executive director of a non-profit organization and whether he may solicit contributions to that organization if the contributions may be used to compensate him. (AOR-573)

SUMMARY

The laws under the Ethics Commission's jurisdiction would not prohibit a legislator from solely receiving compensation from the organization under the stated facts, provided that the compensation reflects the actual value of the legislator's services and not because of his status as a public servant; the services are provided in a capacity other than as a public servant and as long as the legislator's official position is not a reason for his employment by the organization; the compensation is not received in exchange for an official act as a public servant; and the compensation is neither a prohibited political contribution nor a gift, loan, or other prohibited expenditure by a registered lobbyist.

A legislator should understand that the solicitation of contributions to an organization for which the legislator serves as executive director and from which the legislator receives compensation for services could be viewed as improper under certain circumstances. Accordingly, a legislator should use extreme caution when soliciting such contributions.

EAO-509. The Texas Ethics Commission has been asked to consider whether a parent for-profit corporation may solicit political contributions from employees of its wholly owned and operated subsidiary for-profit corporations to a general-purpose committee assisted by the parent corporation. (AOR-575)

SUMMARY

A parent for-profit corporation that assists a general-purpose committee under section 253.100(a) may solicit political contributions to the committee from the employees of a subsidiary for-profit corporation that it wholly owns and operates.

EAO-510. The Texas Ethics Commission has been asked to consider whether a general-purpose committee may accept political contributions by text message. (AOR-576)

SUMMARY

A general-purpose committee may accept political contributions by text message if the committee's campaign treasurer is able to obtain the contributor information necessary to comply with the reporting requirements of Title 15 of the Election Code. A general-purpose committee would not be prohibited from accepting certain factored payments described in this opinion from a connection aggregator if the terms of the factoring agreement between the aggregator and the political committee reflect the usual and normal practice of the industry and are typical of the terms of agreements offered by the aggregator to other political and non-political customers.

EAO-511. The Texas Ethics Commission has been asked to consider whether a signature on a petition for a place on the ballot constitutes a political contribution that may not be accepted by a judicial candidate during the period in which the candidate is prohibited from accepting political contributions. (AOR-577)

SUMMARY

The Judicial Campaign Fairness Act would not prohibit a candidate for judicial office from merely accepting a person's signature on a petition.

The Texas Ethics Commission is authorized by §571.091 of the Government Code to issue advisory opinions in regard to the following statutes: (1) Chapter 572, Government Code; (2) Chapter 302, Government Code; (3) Chapter 303, Government Code; (4) Chapter 305, Government Code; (5) Chapter 2004, Government Code; (6) Title 15, Election Code; (7) Chapter 159, Local Government Code; (8) Chapter 36, Penal Code; (9) Chapter 39, Penal Code; (10) §2152.064, Government Code; and (11) §2155.003, Government Code.

Questions on particular submissions should be addressed to the Texas Ethics Commission, P.O. Box 12070, Capitol Station, Austin, Texas 78711-2070, (512) 463-5800.

TRD-201300450
Natalia Luna Ashley
Special Counsel
Texas Ethics Commission
Filed: February 5, 2013

♦ ♦ ♦

PROPOSED RULES

Proposed rules include new rules, amendments to existing rules, and repeals of existing rules. A state agency shall give at least 30 days' notice of its intention to adopt a rule before it adopts the rule. A state agency shall give all interested persons a reasonable opportunity to submit data, views, or arguments, orally or in writing (Government Code, Chapter 2001).

Symbols in proposed rule text. Proposed new language is indicated by underlined text. [~~Square brackets and strikethrough~~] indicate existing rule text that is proposed for deletion. "(No change)" indicates that existing rule text at this level will not be amended.

TITLE 4. AGRICULTURE

PART 1. TEXAS DEPARTMENT OF AGRICULTURE

CHAPTER 7. PESTICIDES

SUBCHAPTER H. STRUCTURAL PEST CONTROL SERVICE

DIVISION 2. LICENSES

4 TAC §7.127

The Texas Department of Agriculture (the department) proposes an amendment to §7.127, concerning fees for structural pest control licensing exams. The department has determined that contracting exam services through a proctored computer-based system will provide a greater convenience for structural pest control applicators, technicians, and apprentices by offering: 1) more testing locations throughout the state; 2) testing opportunities of at least five days per week; and 3) 24-hour online exam registration. Through outsourcing structural pest control exams, the department will be able to reduce expenditures during fiscal year 2013 below the amount appropriated for the purpose of administering Structural Pest Control exams. As a direct result of this cost savings, the department is proposing an amendment to §7.127 to decrease fees for structural pest control exams by fifteen percent. Additionally, this amendment will comply with changes made to the structural pest control program by the 82nd Texas Legislature, which required that all of the costs of administering this program be entirely offset by revenue generated for the program, including other direct and indirect expenses, and has authorized the agency to collect fees accordingly.

The amendment to §7.127 decreases the fees for an exam in each category from $75 to $64.

Leslie Smith, Director for Consumer Service Protection, has determined for the first five-year period the proposed amendment is in effect, there will be fiscal implications for state government due to the decrease in fees collected. The estimated decrease in revenue is $297,765. There is no anticipated fiscal impact for local governments as a result of administering or enforcing the rule amendment as proposed.

Ms. Smith has also determined that for each year of the first five years the proposed amendment is in effect, the public benefit anticipated will be lower costs necessary to administer exams for the department's Structural Pest Control Service. In addition, there will be greater convenience to the industry by scheduling testing throughout the state five days a week. There is no anticipated additional cost to microbusinesses, small businesses, or persons required to comply with the proposed amendment.

Comments on the proposal may be submitted to Leslie Smith, Director for Consumer Service Protection, Texas Department of Agriculture, P.O. Box 12847, Austin, Texas 78711. Comments must be received no later than 30 days from the date of publication on the proposal in the *Texas Register.*

The amendment to §7.127 is proposed under Occupations Code, §1951.201, which designates the department as the sole authority in the state for licensing persons engaged in the business of structural pest control, and provides the department with the authority to establish fees under Chapter 1951 in amounts reasonable and necessary to cover the costs of administering the department's programs and activities under Chapter 1951.

The code affected by the proposal is the Occupations Code, Chapter 1951.

§7.127. Fees.

Applicants, licensees and continuing education providers will be charged the following fees:

(1) - (8) (No change.)

(9) $64 [~~$75~~] for administering exams in each category;

(10) - (12) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300432
Dolores Alvarado Hibbs
General Counsel
Texas Department of Agriculture
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 463-4075

♦ ♦ ♦

TITLE 16. ECONOMIC REGULATION

PART 1. RAILROAD COMMISSION OF TEXAS

CHAPTER 3. OIL AND GAS DIVISION

16 TAC §§3.13, 3.99, 3.100

The Railroad Commission of Texas (Commission) withdraws the proposed amendments to §3.13, relating to Casing, Cementing, Drilling, and Completion Requirements; §3.99, relating to Cathodic Protection Wells; and §3.100, relating to Seismic Holes

and Core Holes, published in the September 7, 2012, issue of the *Texas Register* (37 TexReg 7021) and proposes revised amendments to these three rules. The Commission proposes the amendments to §3.13 to implement certain provisions of House Bill 2694 (82nd Legislature, Reg. Sess. 2011) and to more clearly outline the requirements for all wells, consolidate the requirements for well control and blow-out preventers, and update the requirements for drilling, casing, cementing, and fracture stimulation. The Commission proposes the amendments to §3.99 and §3.100 to conform the definition of "protection depth."

RECENT RULEMAKING HISTORY

The Commission received numerous comments to the proposed amendments published in the September 7, 2012, issue of the *Texas Register* (37 TexReg 7021). Commission staff also held several workshops across the state and met with interested parties on an individual basis to address various concerns. The Commission extended the formal comment period from October 9, 2012, to November 20, 2012, and held a public hearing in Austin on October 19, 2012. The Commission revised the proposed amendments in response to all of the comments received throughout this time, and on December 11, 2012, circulated a revised draft for informal comment. The Commission appreciates the interest shown by the public in this rulemaking effort since its inception in September 2012, and offers this updated, revised rule proposal for public review and comment, which includes a brief explanation of how certain concerns which came to the Commission's attention have been addressed in the current proposal.

Definition of productive zone

The proposed amendments published by the Commission in the September 7, 2012, issue of the *Texas Register* included an amendment to the definition of "productive horizon." The Commission proposed to amend the term to "productive zone" and define the term as "any stratum known to contain oil, gas, or geothermal resources or formation fluids in the area or capable of allowing migration of oil, gas, or formation fluids up the annulus." In response to numerous comments that this definition was much too broad, the Commission is proposing to return to the original definition: "Any stratum known to contain oil, gas, or geothermal resources in commercial quantities in the area." The concept of potential flow zone and zones with corrosive fluids has been separated.

Definition of potential flow zone

The Commission is proposing a new term, "potential flow zone," to address those zones that can cause bradenhead pressure in an annulus when the zone is not isolated. The Commission has identified numerous such zones and has required that operators set plugs across those zones when a well is plugged. The information that the Commission used to identify these zones comes from industry, which is in a better position to quickly identify new potential flow zones in new areas during drilling. Therefore, the Commission is proposing a definition that reflects that both the Commission and industry will identify these zones: "A zone designated by the director or identified by the operator using available data that needs to be isolated to prevent sustained pressurization of the surface casing, intermediate casing, or production casing annulus sufficient to cause damage to casing and/or cement in a well such that it presents a threat to subsurface water or other subsurface resources, or sufficient to cause the fluids in the annulus to maintain a static fluid level at or less than 250 vertical feet below the protection depth."

Cement sheath thickness

The Commission initially proposed that the diameter of each section of the wellbore in which casing will be set and cemented must be at least two and one-half (2.5) inches greater than the nominal outside diameter of casing to be installed, such that the cement sheath is no less than one and a quarter (1.25) inches, unless otherwise approved by the district director. In response to numerous comments, the Commission will propose a revised requirement as follows:

(3) Wellbore diameters.

(A) The diameter of the wellbore in which surface casing will be set and cemented shall be at least one and one-half (1.5) inches greater than the nominal outside diameter of casing to be installed, unless otherwise approved by the district director.

(B) For subsequent casing strings, the diameter of each section of the wellbore for which casing will be set and cemented shall be at least one (1) inch greater than the nominal outside diameter of the casing to be installed, unless otherwise approved by the district director.

(C) The casing diameter requirements in subparagraphs (A) and (B) do not apply to reentries, liners, and expandable casing.

The Commission received numerous comments about this proposed requirement. Almost all of the industry commenters stated that a 2.5 inch diameter difference from casing to the borehole wall is too restrictive and is not standard industry practice. The Commission agreed with these commenters. American Petroleum Institute (API) Technical Report 10TR1, Second Edition, September 2008, states that: (1) cement evaluation logs require a minimum of 3/4-inch cement sheath to sufficiently attenuate the sonic signal and attain a good log response; and (2) a minimum sheath thickness of 0.75 in. is recommended as a low range, with an optimal range of sheath thickness of 1.5 inches with proper centralization or standoff requirements of a minimum of 70%. For a particular well, the optimum values for these parameters should be calculated from programs that consider cement slurry placement and cement sheath integrity. (See *"Should Horizontal Sections Be Cemented and How to Maximize Value,"* Ilseng J.R., Hoskins L.R., Matthews H.L., Fuller G.A., Pronger D. and Ravi K. 2005, Paper SPE 94288-MS, presented at SPE Production and Operations Symposium, Oklahoma City, OK, SPE-94288-MS.) A review of literature and discussions with industry experts indicates that, while 3/4-inch cement sheath is necessary to obtain a good sonic log response, other cement evaluation tools can be successfully conducted with a lesser thickness.

Casing to be cemented across and extending above the following: all formations permitted for injection or disposal within a quarter of a mile radius of the well to be drilled; productive zones; potential flow zones; and zones with corrosive formation fluids

The proposed amendments originally required that casing be cemented across and 600 feet above all formations permitted for injection or disposal within a quarter of a mile radius of the well to be drilled, as well as across and above, productive zones, potential flow zones, and zones with corrosive formation fluids. However, in response to comments, and in order to decrease the potential costs of this requirement and to make the requirement consistent with long-standing practice in the Commission's Underground Injection Control program, the Commission is proposing to allow the use of calculation, temperature survey, or a cement evaluation tool to determine the top of cement. The pro-

posed amendment would require cement across and: (1) 600 feet above the zone(s) to be isolated if the top of cement is determined by calculation; (2) 250 feet above the zone to be isolated if the top of cement is to be determined by temperature survey; (3) 100 feet above the zone to be isolated if the top of cement is to be determined using a cement evaluation tool; or as otherwise determined by the district director. An operator would presumably consider the various costs associated with each method (e.g., the cost of cement, the cost of the cement squeeze, the cost of downtime, and the cost of a temperature or cement evaluation tool) in order to determine the most cost effective method of complying with this requirement.

§3.13(b)(1)(I) Surface casing evaluation or pressure test after drillout after 360 rotating hours

The Commission has knowledge of several instances in which surface casing was damaged during drilling due to rotation of the drill pipe and other activities after the surface casing was set and cemented in the hole. The initial proposal published in the September 7, 2012, issue of the *Texas Register* would have required a pressure test of the surface casing in all wells after drilling to the depth of the next casing string or to total depth. In response to comments, the Commission is proposing amended language that allows an operator to verify casing integrity through the use of a casing evaluation tool (in lieu of a mechanical integrity test), and only applies this requirement to surface casing that has been exposed to more than 360 rotating hours. This change would more effectively target the wells with which the Commission has concerns and would typically not apply to shallower wells drilled by small and micro businesses.

§3.13(a)(7) Additional requirements for wells on which HFT will be performed

The proposed amendments would require that an operator conduct a successful mechanical integrity test before beginning hydraulic fracturing treatment(s). This requirement is necessary to help ensure the integrity of the casing and cement in the wellbore under anticipated maximum pressure during hydraulic fracturing treatment(s) to protect water and other subsurface resources.

The proposed amendments also would require that operators monitor all annuli on a well during hydraulic fracturing treatment(s). The pressure during a hydraulic fracturing treatment should be contained in the casing string or fracture tubing through which the fluids are pumped. Unexpected changes in the monitored pressure(s) provide an early indication of a possibility that well integrity has been compromised. The Commission anticipates that operators already monitor the annuli during hydraulic fracturing treatment operations.

Minimum separation wells

Minimum separation wells are a subset of wells on which hydraulic fracturing treatments are conducted. The proposed amendments would require that the operator run a cement evaluation tool to assess radial cement integrity and placement behind production casing. The proposed amendments also allow for an exception to this requirement from the district director upon demonstration that the operator has successfully set, cemented, and tested the casing for which the exemption is requested in at least five minimum separation wells in the same field; obtained cement evaluation tool logs that support the findings of cementing records, annular pressure monitoring results or other tests demonstrating that successful cement placement was achieved to isolate productive zones, potential flow zones, and/or zones with corrosive formation fluids; and shown that the well for which the exemption is requested will be constructed and cemented using the same or similar techniques, methods, and cement formulation used in the five wells that have had successful cement jobs. Consistent with the proposed definition of minimum separation well, the Commission anticipates that these wells will be relatively shallow wells.

Notification to district director of surface casing to be set deeper than 3,500 feet

Proposed new subsection (b)(1)(A) would require that an operator notify and obtain the approval of the appropriate district director before setting surface casing deeper than 3,500 feet. The purpose of this requirement is to allow the district director to determine whether or not there have been well control issues in the area of the proposed well. Many wells, including wells in the Eagle Ford field, require the operator to set surface casing deeper than 3,500 vertical feet in order to protect usable quality water as determined by the Commission's Groundwater Advisory Unit. In these cases, a blowout preventer cannot be installed. This proposed requirement is designed to prevent well control issues.

The proposed rule allows for variances or exceptions to many of these requirements as long as the proposed activity meets the intent of the rule as stated in §3.13(a)(1). Variances would require a written request to the district office. The proposed rule would allow area variances in certain instances.

Currently, the rule requires that all flowing oil wells be equipped with and produced through tubing. However, installation of tubing in certain oil wells drilled today could greatly impair production. In proposed subsections (b)(4)(B) and (d), the proposed rule would allow for temporary exceptions (up to 180 days) to the requirement that all flowing oil wells be produced through tubing.

CURRENT PROPOSAL

The proposed amendments to §3.13 more clearly outline the requirements for all wells, consolidate the requirements for well control and blowout preventers, and update the requirements for drilling, casing, cementing, and fracture stimulation. The proposed amendments also add additional requirements for "minimal separation wells," which are wells in which the distance between the protection depth as defined by the rule and the top of the formation to be fracture stimulated is less than 1,000 vertical feet. The proposed amendments also add headers to clarify the rule requirements.

The Commission proposes to amend §3.13(a)(1) to add a header to clarify that the paragraph concerns the intent of the rule and to require that potential flow zones and zones with corrosive formation fluids be isolated.

The Commission proposes to amend several definitions and add new definitions in §3.13(a)(2). The Commission proposes to amend the first sentence in paragraph (2) to replace the word "chapter" with the word "section."

The Commission proposes to amend the definition of "stand under pressure" to add the phrase "and/or float shoe."

The Commission proposes to amend the definition of "zone of critical cement" to clarify that, for intermediate or production casing strings, the bottom 20% of the casing string or not less than 300 vertical feet above the casing shoe or to the top of the highest proposed productive zone.

The Commission proposes to amend the definition of "protection depth" to implement certain provisions of House Bill 2694,

which was passed by the 82nd Texas Legislature and signed into law by the Governor in 2011. Article 2 of HB 2694 transferred from the Texas Commission on Environmental Quality (TCEQ) to the Commission duties relating to the protection of groundwater resources from oil and gas associated activities. Specifically, the law transfers from the TCEQ to the Commission, effective September 1, 2011, duties pertaining to the responsibility of preparing groundwater protection advisory/recommendation letters. After the transfer, the Commission will be responsible for providing surface casing and/or groundwater protection recommendations for oil and gas activities under the jurisdiction of the Commission. The TCEQ's Surface Casing Program and staff have transferred to the Commission effective September 1, 2011. The Surface Casing Program has been renamed the Groundwater Advisory Unit, and is now located in the William B. Travis Building, 1701 North Congress, Austin. The Commission proposes to amend §3.13(a)(2)(C) to replace the phrase "Texas Commission on Environmental Quality or its successor agencies."

The Commission proposes to replace the term "productive horizon" in §3.13(a)(2)(D) with the term "productive zone."

The Commission proposes to add a new definition for "associated gas zone" to mean a zone in which natural gas, commonly known as gas cap gas, overlies and is in contact with crude oil in a reservoir. The term is used in the current rule, but has not been previously defined.

The Commission proposes to add new definitions for "bay well," "land well," and "offshore well" and to define those terms as they currently are defined in §3.78 (relating to Fees and Financial Security Requirements). The Commission proposes to use the term "bay well" to replace the phrase "well in onshore and inland waters."

The Commission proposes to add a new definition for "deputy director of Field Operations" to mean the deputy director of Field Operations of the Oil and Gas Division or the deputy director's delegate.

The Commission also proposes to add a new term "director" and to define the term to mean the director of the Commission's Oil and Gas Division or the director's delegate.

The Commission proposes to add a new definition for "district director" and to define the term to mean the director of a Commission district office or the district director's delegate.

The Commission also proposes to add the new term "hydraulic fracturing treatment" and to define the term as a completion process involving the treatment of a well by the application of hydraulic fracturing fluid under pressure for the express purpose of initiating and/or propagating fractures in a target geologic formation to enhance production of oil and/or natural gas.

The Commission proposes to add the new term "minimum separation well" and to define that term to mean a well in which hydraulic fracturing treatments will be conducted in which: (i) the vertical distance between the base of usable quality water and the top of the formation to be stimulated is less than 1,000 vertical feet; (ii) the director has determined contains inadequate separation between the base of usable quality water and the top of the formation in which hydraulic fracturing treatments will be conducted; or (iii) the director has determined is in a structurally complex geologic setting. Commission records indicate that wells in a handful of fields meet this description. Additional restrictions and consideration are appropriate for wells of this category on which fracture stimulation will be performed. Discussion of how the Commission developed this definition follows later in this preamble.

The Commission proposes to add a definition for the term "potential flow zone" to mean a zone designated by the director or identified by the operator using available data that needs to be isolated to prevent sustained pressurization of the surface casing/intermediate casing or production casing annulus sufficient to cause damage to casing and/or cement in a well such that it presents a threat to subsurface water or other subsurface resources, or sufficient to cause the fluids in the annulus to maintain a static fluid level at or less than 250 vertical feet below the protection depth.

The Commission proposes to add a new definition for "zone with corrosive formation fluids" to mean any zone containing formation fluids that are capable of negatively impacting the integrity of casing and/or cement or have a demonstrated trend of failure for similar casing and cement design in the field.

The Commission proposes to add new §3.13(a)(3), relating to wellbore diameters, to require that the diameter of the wellbore in which surface casing will be set and cemented must be at least one and one-half (1.50) inches greater than the nominal outside diameter of casing to be installed, and, for subsequent casing strings, to require that the diameter of each section of the wellbore for which casing will be set and cemented be at least one inch greater than the nominal outside diameter of the casing to be installed, unless otherwise approved by the district director. The casing diameter requirements do not apply to re-entries, liners, and expandable casing. The new paragraph also would require that the wellbore diameter be consistent with manufacturer's recommendations for all float equipment; centralizers, packers, cement baskets, and all other equipment run into the wellbore on casing. The Commission proposes to add the new paragraph to ensure that there is sufficient annular space to ensure an adequate cement bond between the casing and the formation.

The Commission proposes to move the language regarding casing from subsection (b)(1)(A) to new subsection (a)(4) and rename the paragraph "casing and cementing" to reflect the fact that the requirements in that paragraph are applicable to all wells. The Commission proposes to amend the language to allow Commission-approved equivalent standards and to update the references. The Commission proposes to delete the language regarding specific tests that may be used as alternatives to hydrostatic testing and to allow the use of a "casing evaluation tool."

In addition, the Commission proposes to add new subsection (a)(4)(C) to require that casing be cemented across and above all formations permitted for injection under §3.9 of this title (relating to Disposal Wells), or §3.46 of this title (relating to Fluid Injection into Productive Reservoirs), within one-quarter mile of the proposed well location and that casing be cemented across and extending above all productive zones, potential flow zones, and zones with corrosive formation fluids. If the top of the cement is determined through calculation, cement must be set across and extending at least 600 feet (measured depth) above the permitted formations; if the top of cement is determined through the performance of a temperature survey, the cement must be set across and extending 250 feet (measured depth) above the permitted formations; if the top of cement is determined through the performance of a cement evaluation log, the cement must be set across and extending 100 feet (measured depth) above the per-

mitted formations; or across and extending at least 200 feet into the previous casing shoe (or to surface if less than 200 feet); or as otherwise approved by the district director. Further, the Commission proposes to require that, where necessary, the cement slurry be designed to control annular gas migration consistent with API Standard 65-Part 2.

The Commission proposes to add new subsection (a)(4)(D) to require that casing be cemented across and above all productive zones, potential flow zones, and/or zones with corrosive formation fluids in a similar manner as required in subsection (a)(4)(C).

The Commission proposes to add new subsection (a)(4)(E) to require that the cement slurry be designed to control annular gas migration consistent with the standards in, or equivalent to the standards in, API Standard 65-Part 2: Isolating Potential Flow Zones During Well Construction.

The Commission proposes to add new subsection (a)(5), relating to casing testing before drillout. The new paragraph would require that, for surface and intermediate strings of casing, before drilling the cement plug, the operator test the casing at a pump pressure in pounds per square inch (psi) calculated by multiplying the length of the true vertical depth in feet of the casing string by a factor of 0.5 psi per foot. The maximum test pressure required, however, unless otherwise ordered by the commission, need not exceed 1,500 psi. If, at the end of 30 minutes, the pressure shows a drop of 10% or more from the original test pressure, the casing shall be condemned until the leak is corrected. A pressure test demonstrating less than a 10% pressure drop after 30 minutes constitutes confirmation that the condition has been corrected. The operator shall notify the district director of a failed test. In the event of a pressure test failure, completion operations may not re-commence until the district director approves a remediation plan, the operator successfully implements the plan, and the operator conducts a successful pressure test.

The Commission proposes to update, and consolidate into new subsection (a)(6), all well control and blowout preventer language. The language in proposed subsection (a)(6)(A) regarding wellhead assemblies is the same language currently found in subsection (b)(1)(B), except that the Commission has added the phrase "after setting conductor pipe and/or surface casing" to the beginning of the subparagraph.

The Commission proposes language in subsection (a)(6), relating to well control equipment, to replace language currently in subsections (b)(1)(C) and (c)(2) - (9) relating to blowout preventers and diverters, Kelly cock, mud program, casinghead, Christmas tree, storm choke and safety valve, pipeline shut-off valve, and training. The Commission also proposes to amend the existing language in these paragraphs to update the requirements. The main revisions involve the required makeup of the blowout prevention systems. In addition, the Commission proposes to add language that would require that all hole intervals drilled prior to reaching the base of protected water be drilled with air, fresh water, or a fresh water based drilling fluid and to prohibit the use of oil based drilling fluid in drilling until the casing has been set and cemented to the protection depth.

The Commission proposes new subsection (a)(7) relating to additional requirements for wells on which hydraulic fracture treatments will be conducted. New paragraph (7)(A) applies to all wells that are fracture stimulated and would require that all casing installed in a well that will be subjected to hydraulic fracturing treatments have a minimum internal yield pressure rating of at least 1.15 times the maximum pressure to which the casing will be subjected. Proposed new paragraph (7)(B) would require that the operator pressure test the casing (or fracture tubing) on which the pressure will be exerted during stimulation to at least the maximum anticipated pressure. The new subparagraph also requires that the operator notify the district director of a failed test within 24 hours of completion of the test and states that no hydraulic fracturing treatment may be conducted until the district director has approved a remediation plan, and the operator has implemented the approved remediation plan and successfully re-tested the casing (or fracture tubing).

The Commission proposes to add new paragraph (a)(7)(C) to require that, during hydraulic fracturing treatment operations, the operator monitor all annuli. The new subsection also would require that the operator immediately suspend hydraulic fracturing treatment operations if the pressures deviates above those anticipated increases caused by pressure or thermal transfer and shall notify the appropriate district director within 24 hours of such deviation. Further completion operations, including hydraulic fracturing treatment operations, may not recommence until the district director approves a remediation plan and the operator successfully implements the approved plan.

Proposed new subsection (a)(7)(D) would apply to a minimum separation well, which is defined in subsection (a)(2)(L) as a well in which hydraulic fracturing treatments will be conducted and for which: (i) the vertical distance between the base of usable quality water and the top of the formation to be stimulated is less than 1,000 vertical feet; (ii) the director has determined contains inadequate separation between the base of usable quality water and the top of the formation in which hydraulic fracturing treatments will be conducted; or (iii) the director has determined is a structurally complex geologic setting. Commission records indicate that wells in a several fields meet this description. Additional restrictions and consideration are warranted for wells of this category on which fracture stimulation will be performed. The Commission selected a distance of 1,000 vertical feet as the default demarcation point for minimum separation wells after reviewing *"Hydraulic Fracture-Height Growth, Real Data,"* (by Kevin Fisher and Norm Warpinski, SPE 145949, SPE Production & Operations, Volume 27, Number 1, February 2012, pp. 8-19) and *"Hydraulic fractures: How far can they go?"* (by Davies, R.J., et al, Marine and Petroleum Geology (2012)). In general, below 2,000 feet, the fractures mostly are oriented vertically; at less than 2,000 feet, they tend to start orienting more horizontally. The recent American Petroleum Institute (API) hydraulic fracturing guidance (API HF Guidance) states that "hydraulic fractures are formed in the direction perpendicular to the least stress. Based on experience, horizontal fractures will occur at depths less than 2000 ft." The guidance further states that "as depth increases, overburden stress in the vertical direction increases by approximately 1 psi/ft. As the stress in the vertical direction becomes greater with depth, the overburden stress (stress in the vertical direction) becomes the greatest stress. This situation generally occurs at depths greater than 2000 ft."

The proposed rule would require cementing of the production casing using sufficient cement to fill the annular space outside the casing from the casing shoe to the ground surface or to the bottom of the cellar. The proposed rule also would require that the production casing be cemented from the shoe up to a point at least 200 feet above the shoe of the next shallower casing string set and cemented in the well. The rule further would require that the operator pressure test the casing string on which the pressure will be exerted during stimulation to the maximum pressure that will be exerted during hydraulic fracturing treatments and

notify the district director within 24 hours of a failed test. In addition, the production casing for any minimum separation well must not be disturbed for a minimum of eight hours after cement is in place, and in no case shall the casing be disturbed until the cement has reached a minimum compressive strength of 500 psi. In addition to conducting an evaluation of cementing records and annular pressure monitoring results, the operator of a minimum separation well must run a cement evaluation tool to assess radial cement integrity and placement behind the production casing. If the cement evaluation indicates insufficient isolation, a remediation plan must be approved by the appropriate district director. The rule would prohibit the operator from re-commencing completion operations until the district director approves the plan and the operator successfully implements the approved plan.

The proposed rule also would allow the operator of a minimum separation well to request from the appropriate district director approval of an exemption from the requirement to run a cement evaluation tool. Such request must include information demonstrating that the operator has: (1) successfully set, cemented, and tested the casing for which the exemption is requested in at least five minimum separation wells by the same operator in the same operating field; (2) obtained cement evaluation tool logs that support the findings of cementing records, annular pressure monitoring results or other tests demonstrating that successful cement placement was achieved to isolate productive zones, potential flow zones, and/or zones with corrosive formation fluids; and (3) shown that the well for which the exemption is requested will be constructed and cemented using the same or similar techniques, methods, and cement formulation used in the five wells that have had successful cement jobs.

The Commission proposes to move the existing language in subsection (c)(8) relating to pipeline shut-off valves for bay and offshore wells to new subsection (a)(8). These requirements apply only to bay and offshore wells as defined by this section.

The Commission proposes to move the language in subsection (c)(9) relating to training to new subsection (a)(9) and to update the language regarding approved training programs.

The Commission proposes to add new subsection (a)(10) to clarify that the Commission may require bottom-hole pressure surveys as it determines is necessary.

The Commission proposes to amend the heading of existing §3.13(b) to "Casing and cementing requirements for land wells and bay wells." The Commission proposes to move and amend the existing language in subsection (b)(1) to subsection (a) as discussed previously.

The Commission proposes to renumber current subsection (b)(2) to subsection (b)(1)(A), and to state there that any proposal to set surface casing to a depth of 3,500 feet or greater shall require prior approval of the appropriate district director. The proposed rule would require a request for such approval to be in writing and to specify how the operator plans to maintain well control during drilling, and ensure successful circulation and adequate bonding of cement, and, if necessary, prevent upward migration of deeper formation fluids into protected water. The district director may grant approvals on an area basis.

The Commission proposes to amend subsection (b)(1)(B)(i) (currently subsection (b)(2)(A)(i) relating to amount required), to replace the phrase "TCEQ" with the phrase "Groundwater Advisory Unit of the Oil and Gas Division." The Commission also proposes to delete obsolete language regarding field rules that specify surface casing requirements. The depth to which all surface casing must be set will be determined by the Commission's Groundwater Advisory Unit.

The Commission proposes to amend subsection (b)(1)(C), relating to cementing, to correct the grammar.

The Commission proposes to amend subsection (b)(1)(C)(iii) (current subsection (b)(2)(C)(iii)) relating to cement quality, to require that the free water content of the cement be minimized to the greatest extent practicable in the cement slurry to be used in the zone of critical cement. The proposed language would require that the free water separation average no more than two milliliters (rather than 6 mil) per 250 milliliters of cement tested in accordance with the current API RP 10B inside the zone of critical cement or more than six milliliters per 250 milliliters of cement tested outside the zone of critical cement.

The Commission proposes to amend subsection (b)(1)(C)(iv) (currently subsection (b)(2)(C)(iv)) to elaborate on the type of conditions in which the Commission may require a better quality of cement mixture to be used in any well or any area where necessary to prevent pollution, isolate productive zones, potential flow zones, or zones with corrosive formation fluids, or prevent a safety issue in the well.

The Commission proposes to amend subsection (b)(1)(D) (currently subsection (b)(2)(E)) relating to compressive strength tests, to update the reference and to allow equipment and procedures equivalent to those in API RP 10B-2.

The Commission proposes to amend subsection (b)(1)(F) (currently subsection (b)(2)(E)) relating to cementing report, to require that the report be filed with the Commission within 30 days of completion of the well or within 90 days of cessation of drilling operations, whichever is earlier.

The Commission proposes to amend subsection (b)(1)(G) (currently subsection (b)(2)(F)) relating to centralizers, to reference the API recommended practices and specifications for various types of centralizers and to allow equivalent practices and specifications.

The Commission proposes to amend subsection (b)(1)(H) (currently subsection (b)(2)(G)) relating to alternative surface casing programs, to clarify that alternative surface casing programs may be requested and to clarify that the deputy director of field operations will review a request that has been denied by the district director. In addition, the Commission proposes to add language that states that the district director shall deny the request if the operator has not demonstrated that the alternative casing plan will achieve the intent of this rule as described in subsection (a)(1) of this section. Furthermore, the Commission proposes to amend the current language to require that a multi-stage tool be set at least 100 feet, rather than 50 feet, below the protection depth.

The Commission proposes to add new subsection (b)(1)(I), relating to mechanical integrity test of the surface casing after drill-out, to require that, if the surface casing is exposed to more than 360 rotating hours, the operator verify the integrity of the casing by using a casing evaluation tool or conducting a mechanical integrity test or equivalent Commission-approved casing evaluation method, unless otherwise approved by the district director. This paragraph would require that, if a mechanical integrity test is conducted, the appropriate district office be notified at least eight hours before the test is conducted. Further, the paragraph would require that the operator use a chart of acceptable range

(20% - 80% of full scale) or an electronic equivalent approved by the district director, and the surface casing be tested at a pump pressure in pounds per square inch (psi), calculated by multiplying the length of the true vertical depth in feet of the casing string by a factor of 0.5 psi per foot up to a maximum of 1,500 psi for a minimum of 30 minutes. A pressure test demonstrating less than a 10% pressure drop after 30 minutes constitutes confirmation of an acceptable pressure test. The appropriate district office shall be notified within 24 hours after a failed test. Completion operations may not re-commence until the district director approves a remediation plan and the operator successfully implements the approved plan and successfully re-tests the surface casing.

The Commission proposes to amend the heading of subsection (b)(2) (currently subsection (b)(3)) from "intermediate casing" to "intermediate casing requirements for land wells and bay wells."

The Commission proposes to amend subsection (b)(2)(A) (currently subsection (b)(3)(A)) relating to cementing method, to replace the term "productive horizon" with "productive zone," and to require cementing of intermediate casing above any potential flow zone or zone with corrosive formation fluids. If the top of cement is determined through calculation, cement must be placed from the shoe up to a point at least 600 feet (measured depth) above the top of the shallowest productive zone, potential flow zone, or zone with corrosive formation fluids; if the top of cement is determined through performance of a temperature survey, cement must be placed from the shoe up to a point at least 250 feet (measured depth) above the top of the shallowest productive zone, potential flow zone, or zone with corrosive formation fluids; if the top of cement is determined through performance of a cement evaluation log, cement must be placed from the shoe up to a point at least 100 feet (measured depth) above the top of the shallowest productive zone, potential flow zone, or zone with corrosive formation fluid; or cement must be placed to a point at least 200 feet (measured depth) above the shoe of the next shallower casing string that was set and cemented in the well (or to surface if the shoe is less than 200 feet from the surface); or as otherwise approved by the district director.

The Commission proposes to add a requirement in new subsection (b)(2)(B) that the calculated or measured top of cement be indicated on the appropriate completion form required by §3.16 of this title (relating to Log and Completion or Plugging Report).

The Commission proposes to amend new subsection (b)(2)(C) (currently subsection (b)(2)(B)) relating to alternate method, to replace the term "productive horizon" with "productive zone" and to allow the use of a multi-stage tool to isolate potential flow zones and/or zones with corrosive formation fluids as required by this section.

The Commission proposes to amend the heading of subsection (b)(3) (currently subsection (b)(4)) from "production casing" to "production casing requirements for land wells and bay wells." The Commission proposes new subsection (b)(3)(A), relating to centralizers, to require that the operator provide additional centralization to ensure zonal isolation between the top of the interval to be completed and the shallower zones that require isolation.

The Commission proposes to amend the existing language in new subsection (b)(3)(B) (currently subsection (b)(4)(A)) relating to cementing methods, to replace the term "productive horizon" with the term "productive zone" and to require that any potential flow zone or zone with corrosive formation fluids be cemented in a manner that effectively seals off those zones. The new subparagraph also would require that a float collar or other means to stop the cement plug must be inserted in the casing string above the shoe. Cement must be allowed to stand under pressure for a minimum of eight hours before drilling the plug or initiating tests. In the event that the distance from the casing shoe to the top of the shallowest productive zone make cementing, as required above, impossible or impractical, the multi-stage process may be used to cement the casing in a manner that will effectively seal off all such possible productive zones, and prevent fluid migration to or from such strata within the wellbore.

The Commission proposes new subsection (b)(3)(C) to require that the calculated or measured top of cement must be indicated on the appropriate completion form required by §3.16 of this title.

The Commission proposes to renumber current subsection (b)(4)(B), relating to isolation of associated gas zones, to subsection (b)(3)(D).

The Commission proposes to amend the heading of subsection (b)(4) (currently subsection (b)(5)) from "tubing and storm choke requirements" to "tubing requirements for land and bay wells." The Commission proposes to amend the language in subsection (b)(4)(A) (currently subsection (b)(5)(A)) to clarify the language regarding liners and to require that the tubing be at a point no higher than 100 feet above the kickoff point in a deviated or horizontal well. In new subsection (b)(4)(B), the Commission proposes to replace language regarding storm chokes with new language regarding alternate tubing requirements. Specifically, the Commission proposes to state that it will authorize alternate programs requesting a temporary exception pursuant to subsection (d) of this section to omit tubing from a flowing oil well only on an individual well basis and that the district director may approve or reject the proposed program. If the proposal is rejected, the operator may request a review by the director of field operations. If the proposal is not approved administratively, the operator may request a hearing. The new language would require an operator to obtain approval of any alternative program before commencing operations.

The Commission proposes to amend the heading of §3.13(c) from "Texas offshore casing, cementing, drilling, and completion requirements" to "Casing, cementing, drilling, and completion requirements for offshore wells," and proposes a minor clarification in paragraph (1).

In subsection (c)(1)(B)(i), the Commission proposes no changes to the existing table other than correcting the Figure reference and the table format. The Commission proposes to amend the heading of subsection (c)(1)(B)(ii) to add the word "surface" and reorganizes the existing language and adds new wording to require that, after drillout of the surface casing, if the surface casing is exposed to more than 360 rotating hours, the operator verify the integrity of the casing using a casing evaluation tool, a mechanical integrity test, or an equivalent Commission-approved alternate casing evaluation methodology, unless otherwise approved by the district director. If a mechanical integrity test of the surface casing is conducted, the appropriate district office shall be notified a minimum of eight hours before the test is conducted, the operator shall use a chart of acceptable range (20% - 80% of full scale) or an electronic equivalent approved by the district director, and the surface casing shall be tested at a minimum test pressure of 0.5 psi per foot multiplied by the true vertical depth of the surface casing up to a maximum of 1,500 psi for a minimum of 30 minutes. A pressure test demonstrating less than a 10% drop in pressure after 30 minutes constitutes confirmation of an acceptable pressure test. The operator shall notify the

appropriate district office within 24 hours of a failed test. Completion operations may not re-commence until the district director approves a remediation plan and the operator successfully implements the approved plan.

The Commission proposes to amend subsection (c)(1)(C) relating to production casing or oil string, to divide the language into three clauses, to clarify the language, and to require that operators isolate "productive zones" as defined in this rule rather than "prospective producing horizons," as well as potential flow zones and/or zones with corrosive formation fluids.

As noted previously, and as noted in new subsection (c)(2), the Commission proposes to move and consolidate the well control requirements of the rule in new subsection (a)(6).

The Commission proposes to add new subsection (d), relating to exceptions or alternate programs, to allow the director to administratively grant an exception or approve an alternate casing/tubing program required by this section provided that the intent of the rule and the following requirements are met. The request for an exception or alternate casing/tubing program must be accompanied by the fee required by §3.78(b)(5) of this title (relating to Fees and Financial Security Requirements). An administrative exception for tubing must not exceed a period of 180 days. A request for an exception for tubing beyond 180 days would require a Commission order.

In §3.99(a)(3) and §3.100(a)(4), the Commission proposes to amend the definition of "protection depth" consistent with the definition in §3.13.

Leslie Savage, Chief Geologist, Oil and Gas Division, has determined that for each year of the first five years that the proposed amendments will be in effect, there will be no foreseeable implications relating to cost or revenues of state or local governments as a result of enforcing or administering the rule as amended. The proposed amendments update §3.13 to implement HB 2694 (82nd Reg. Sess. 2011) to reflect a change in jurisdiction. Specifically, the law transfers from the TCEQ to the Commission, effective September 1, 2011, duties pertaining to the responsibility of preparing groundwater protection advisory/recommendation letters. The change makes the Railroad Commission responsible for providing surface casing and/or groundwater protection recommendations for oil and gas activities under the jurisdiction of the Railroad Commission. The Commission accounted for the fiscal impacts of this change in the preamble to the proposed amendments to §3.78, published in the September 9, 2011, issue of the *Texas Register* (36 TexReg 5771). The proposed amendments in §3.13 also update the casing and cementing requirements, consolidate and update well control requirements, and add new requirements for minimum separation wells. Many of the proposed amendments are clarification of current requirements, clarification of requirements to meet the existing intent of the rule, or updates to reflect current industry best practices.

Ms. Savage has determined that for each year of the first five years that the amendments will be in effect, the public benefit will be consolidation of duties related to the protection of groundwater resources from oil and gas associated activities in the agency that also is responsible for regulation of oil and gas activities, clearer regulations, up-to-date references to standards, and greater protection of Texas natural resources.

Texas Government Code, §2006.002, relating to Adoption of Rules with Adverse Economic Effect, requires that as part of the rulemaking process, a state agency prepare an Economic Impact Statement that assesses the potential impact of a proposed rule on small businesses and micro-businesses and a Regulatory Flexibility Analysis that considers alternative methods of achieving the purpose of the rule if the proposed rule will have an adverse economic effect on small businesses or micro-businesses. Entities that perform activities under the jurisdiction of the Commission are not required to report to the Commission their number of employees or their annual gross receipts, which are elements of the definitions of "micro-business" and "small business" in Texas Government Code, §2006.001; therefore, the Commission has no factual bases for determining whether any persons who drill and complete wells under the jurisdiction of the Railroad Commission will be classified as small businesses or micro-businesses, as those terms are defined. Specifically, Texas Government Code, §2006.001(2), defines a "small business" as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit; is independently owned and operated; and has fewer than 100 employees or less than $6 million in annual gross receipts. Texas Government Code, §2006.001(1), defines "micro-business" as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit; is independently owned and operated; and has not more than 20 employees. The North American Industrial Classification System (NAICS) sets forth categories of business types. Operators of oil and gas wells fall within the category for crude petroleum and natural gas extraction. This category is listed on the Texas Comptroller of Public Accounts website page entitled "HB 3430 Reporting Requirements-Determining Potential Effects on Small Businesses" as business type 2111 (Oil & Gas Extraction), for which there are listed 2,784 companies in Texas. This source further indicates that 2,582 companies (92.7%) are small businesses or micro-businesses as defined in Texas Government Code, §2006.002. Any number of these businesses could be affected under the proposed amendments.

However, the Commission anticipates that the proposed amendments will have a relatively small adverse economic impact on those entities engaged in oil and gas well operations in Texas, taking into account that the cost of drilling and completing a well today is generally between $250,000 and $4 million and that most operators already are implementing industry best practices consistent with these proposed amendments. The cost will depend upon numerous variables that cannot be quantified, including the characteristics of the formations through which an operator drills, cases and cements a well, and the extent to which the operator already complies by virtue of the use of industry best practices. The economic impact of the cost of compliance with the proposed amendments will be less for small businesses and micro-businesses which generally drill and complete shallower, less expensive wells, than larger businesses, which generally drill and complete deeper, more expensive wells. Every operator, whether it is a small business or micro-business or not, must comply with the same provisions of the rule if it drills, cases and cements a well under jurisdiction of the Railroad Commission.

Based on the information available to the Commission regarding oil and gas operators, Ms. Savage has concluded that, of the businesses that could be affected by the proposed amendments, it is likely that many would be classified as small businesses, and possible that some could be classified as micro-businesses, as those terms are defined in Texas Government Code, 2006.001. The proposed amendments would add requirements that will result in increased drilling and completion costs for many wells.

Small and micro-businesses represent a large percentage of entities operating in the crude oil and natural gas extraction industry. As such, the rule amendments are likely to affect a significant number of small and micro-businesses.

The Commission has estimated the additional cost per well resulting from the proposed amendments using two types of wells as examples--a relatively shallow well at a total depth of 3,000 vertical feet, and a deep well at 10,000 vertical feet total depth. The Commission used the following estimated costs: Cement bond log = $9,000 + $1,950/hour wait time Mechanical integrity test = $10,000 to $30,000 (depending on the length of casing to be tested) Average cost of drilling a deep horizontal well = $4,171,700

The 2007 U.S. Energy Information Administration's "Costs of Crude Oil and Natural Gas Wells Drilled" estimated that the average cost of drilling a deep, horizontal well was $4,171,700. The Commission was advised that the minimum cost of drilling and completing a shallow well (2,000 to 3,000 vertical feet total depth) is approximately $250,000.

Proposed new subsection (a)(4)(C) would require that casing be cemented across and extending above the following zones: all formations permitted for injection or disposal within a quarter of a mile radius of the well to be drilled; productive zones; potential flow zones; and zones with corrosive formation fluids. In order to decrease the potential costs of this requirement and to make the requirement consistent with long-standing practice in the Commission's Underground Injection Control program, the Commission is proposing to allow the use of calculation, temperature survey, or cement evaluation tool to determine the top of cement. The proposed rule would require cement across and (1) 600 feet above the zone(s) to be isolated if the top of cement is determined by calculation; (2) 250 feet above the zone to be isolated if the top of cement is to be determined by temperature survey; (3) 100 feet above the zone to be isolated if the top of cement is to be determined using a cement evaluation tool; or as otherwise determined by the district director. The operator would presumably consider the various costs associated with each method (e.g., the cost of cement, the cost of the cement squeeze, the cost of downtime, and the cost of a temperature or cement evaluation tool) in order to determine the most cost-effective method of complying with this requirement.

To calculate the potential additional costs of placing cement behind the production casing, the Commission used an example of a shallow well of 3,000 vertical feet total depth, with one potential flow zone and one zone with corrosive formation fluids, each approximately 100 feet thick. Estimated costs are:

Calculated top of cement: (700 feet cement X 2 X $3.11/foot of cement) + (0 hours rig time X $1,950/hour) = $4,354

Determine top of cement by temperature survey: (350 feet cement X 2 X $3.11/foot of cement) + (12 hours rig time X $1,950/hour) + $6,000 temperature survey = $31,577

Determine top of cement by cement evaluation tool: (200 feet cement X 2 zones X $3.11/foot of cement) + (0 hours rig time X $1,950/hr) + $9,000 = $10,244

The Commission also used the example of a deep horizontal well of 10,000 vertical feet total depth, with one potential flow zone, one zone with corrosive fluids, and one zone that is used by an injection well within a quarter mile for disposal of oil and gas waste. The Commission assumed that the cement would need to be placed behind the production string. The Commission assumed each zone was 100 feet thick. Estimated costs in this case are:

Calculated top of cement: (700 feet cement X 3 X $3.11/foot of cement) = $6,531

Determine top of cement by temperature survey: (350 feet cement X 3 X $3.11/foot of cement) + (18 hours rig time X $1,950/hour) + $6,000 = $44,366

Determine top of cement by cement evaluation tool: (200 feet cement X 3 zones X $3.11/foot of cement) + $9,000 = $10,866

Therefore, using the most cost-effective option, the additional cost of this requirement would be 1.74 percent of the cost of drilling and completing a shallow well and 0.16 percent of the cost of drilling and completing a deep horizontal well.

Proposed new subsection (b)(1)(I) would require evaluation or pressure testing of surface casing after drillout if the surface casing is exposed to more than 360 rotating hours. The new subsection would allow alternate methods of Commission-approved evaluation of the surface casing or would allow an exception to this requirement if approved by the district director.

If a mechanical integrity test (MIT) of the surface casing were conducted, the Commission estimates that the proposed new requirement would result in the following additional costs: $10,000 for the MIT plus stand-by time of 12 hours at approximately $1,950 per hour, for a total of $33,400. The Commission anticipates that this requirement would apply almost exclusively to relatively deep wells.

Proposed new subsection (a)(7) would impose additional requirements on wells on which hydraulic fracturing treatments will be conducted.

The proposed amendments would require that all casing installed in a well that will be subjected to hydraulic fracturing treatments shall have a minimum internal yield pressure rating of at least 1.15 times the maximum pressure to which the casing may be subjected. This requirement should result in no additional cost as operators have advised the Commission that the maximum pressure during a hydraulic fracturing treatment is 85 percent of the pressure rating of the casing upon which the pressure is exerted.

The proposed amendments would require that an operator conduct a successful MIT on the casing (or tubing) string on which the pressure will be exerted during hydraulic fracturing treatments before beginning hydraulic fracturing treatments. This proposed requirement would ensure the integrity of the casing and cement in the wellbore under anticipated pressure during hydraulic fracturing treatments to protect water and other subsurface resources. The Commission estimates that this proposed new requirement would result in an additional cost of $5,000, for a shallow well, and $7,500 for the MIT for a deep well.

The proposed amendments also would require that the operator monitor all annuli during a hydraulic fracturing treatment. The pressure during a hydraulic fracturing treatment should be contained in the casing string or fracture tubing through which the fluids are pumped. Unexpected changes in the monitored pressures provide an early indication of a possibility that well integrity has been compromised. However, there should be no cost associated with this requirement, because operators already monitor the annuli during hydraulic fracturing treatment operations.

Minimum separation wells are a subset of wells on which hydraulic fracturing treatments are conducted. The proposed

amendments would require that the operator run a radial cement evaluation tool to assess cement integrity and placement behind production casing. The proposed amendments also allow for an exception to this requirement from the district director upon demonstration that the operator has successfully set, cemented, and tested the casing for which the exemption is requested in at least five minimum separation wells in the same field; obtained cement evaluation tool logs that support the findings of cementing records, annular pressure monitoring results or other tests demonstrating that successful cement placement was achieved to isolate productive zones, potential flow zones, and/or zones with corrosive formation fluids; and shown that the well for which the exemption is requested will be constructed and cemented using the same or similar techniques, methods, and cement formulation used in the five wells that have had successful cement jobs. Consistent with the proposed definition of minimum separation well, the Commission anticipates that these wells will be relatively shallow wells. The Commission estimates that these requirements would result in an additional cost of $70,000 (five wells X ($9,000/Cement evaluation tool + $5,000/MIT).

Proposed new subsection (b)(1)(A) would require that an operator notify the district director before setting surface casing to a depth of 3,500 feet or greater. The purpose of this requirement is to allow the district director to determine whether or not there have been well control issues in the area of the proposed well. The Commission's Groundwater Advisory Unit requires operators of many wells, including wells in the Eagle Ford field, to set surface casing deeper than 3,500 vertical feet in order to protect usable quality water. In these cases, a blowout preventer cannot be installed. This proposed requirement is designed to prevent well control issues. There should be no significant additional costs as a result of this proposed new requirement.

Proposed new subsection (b)(3)(A) would require production casing centralizers on horizontal/deviated wells as necessary to keep casing centered in the wellbore and ensure cement is evenly distributed between the casing and the wellbore. The Commission added the phrase "as necessary" to allow operators to design their centralizer program to ensure even distribution of cement behind the casing. The Commission anticipates that operators already are designing their wells in this manner; therefore, there should be no additional costs.

The proposed rule allows for exceptions to these requirements as long as the proposed activity meets the intent of the rule as stated in §3.13(a)(1). Exceptions would require a verbal or written request to the district office. The proposed rule would allow area variances in certain instances. The Commission estimates that operators preparing and submitting a written request for an exception could incur a maximum administrative cost of approximately $250 for each request. This cost would be offset by the cost saved as a result of the exception.

Currently, the rule requires that all flowing oil wells be equipped with and produced through tubing. However, installation of tubing in certain oil wells drilled today could greatly impair production. In proposed (b)(4)(B), the proposed rule would allow for temporary exceptions (up to 180 days) to the requirement that all flowing oil wells be produced through tubing. Such exceptions would require an exception fee (exception fee of $150 + $ 225 surcharge = $375 for each exception). The Commission estimates that operators requesting such temporary exceptions could incur a maximum administrative cost of approximately $250 for each exception request, for a maximum total of approximately $625 for each request. However, the cost of such an exception would be offset by the operator's ability to immediately produce the oil well without tubing and during the exception period.

Wells that are poorly constructed may not sufficiently isolate zones that can cause fluid to migrate up the borehole/casing annulus and impact other productive zones or water resources. The costs incurred by the proposed amendments could be offset by potential costs for remediation of a well or subsurface water or other resources that have been damaged because of improper construction.

Pursuant to Texas Government Code, §2001.022, the Commission has determined that the proposed rulemaking will not have an adverse impact on local employment; therefore, the Commission has not prepared a local employment impact statement.

The Commission has determined that the proposed rule does not meet the statutory definition of a major environmental rule as set forth in Texas Government Code, §2001.0225; therefore, a regulatory analysis pursuant to section is not required.

The Commission reviewed the proposed rules and found that they are neither identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11(b)(2) or (4), nor will they affect any action/authorization identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11(a)(6). Therefore, the proposed rule is not subject to the Texas Coastal Management Program.

The Commission also has determined that a regulatory flexibility analysis is not required because including any additional alternative regulatory methods that will achieve the purpose of the proposed amendments while minimizing the adverse impacts on small businesses and micro-businesses is not consistent with the terms of Texas Natural Resources Code, §91.011, which requires that the operator of a well being drilled for oil or gas shall encase the well with good and sufficient steel casing or with any other material that meets standards adopted by the commission, particularly where wells could be subjected to corrosive elements or high pressures and temperatures, in a manner and to a depth that will exclude surface or fresh water from the lower part of the well from penetrating the oil or gas bearing rock, and if the well is drilled through the first into the lower oil or gas bearing rock, the well shall be cased in a manner and to a depth that will exclude fresh water above the last oil or gas bearing rock penetrated, or with Commission policies of assuring that wells under the Commission's jurisdiction are drilled, cased, cemented, and operated safely. Wells that are not constructed and operated in accordance with §91.011 would pose a potential risk of blowout and of adversely impacting usable quality water. As noted previously in this preamble, the Commission has endeavored in response to comments to eliminate as much of the cost as possible, while still addressing the issues with which these proposed amendments are concerned. Such changes include a change in the definition of productive zone and potential flow zone; reduction in the height of cement behind the casing across and above certain zones that must be isolated depending on the method of determining the top of cement; deletion of a requirement to submit a written remediation plan to the Commission after a failed mechanical integrity test or casing evaluation; changes regarding mud level indicators and mud-gas separation equipment; and the availability of additional variance or exception opportunities. Such changes decrease the anticipated additional costs of the proposed amendments for all operators, but the percentage of reduction is greater for small and micro-businesses. There are

no additional alternative regulatory methods that will achieve the purpose of the proposed amendments while minimizing the adverse impacts on small businesses and micro-businesses; exempting small businesses and micro-businesses from the requirements of the rules would not be consistent with the economic or environmental welfare of the state, nor with the intent of §3.13(a)(1), including the proposed amendments.

Comments on the proposal may be submitted to Rules Coordinator, Office of General Counsel, Railroad Commission of Texas, P.O. Box 12967, Austin, Texas 78711-2967; online at www.rrc.state.tx.us/rules/commentform.php; or by electronic mail to rulescoordinator@rrc.state.tx.us. Comments should refer to O&G Docket No. 20-0277738 and will be accepted until 12:00 p.m. (noon) on Monday, April 1, 2013, which is 45 days after publication in the *Texas Register.* The Commission finds that this comment period is reasonable because the proposal as well as an online comment form will be available on the Commission's web site at least two weeks prior to *Texas Register* publication of the proposal, giving interested persons additional time to review, analyze, draft, and submit comments.

In addition, the Commission will hold a public hearing concerning these proposed rule amendments on Thursday, February 21, 2013, from 1:30 to 3:30 p.m. in Room 1-111 at the Commission's Austin office at the William B. Travis Building, 1701 North Congress Ave., Austin, Texas 78701. The Commission encourages all interested persons to attend the hearing and offer comments or statements, either verbally or in writing, or to otherwise submit comments to the Commission no later than the deadline of 12:00 p.m. (noon) on April 1, 2013. The Commission cannot guarantee that comments submitted after the deadline will be considered. For further information, call Ms. Savage at (512) 463-7308. The status of Commission rulemakings in progress is available at www.rrc.state.tx.us/rules/proposed.php.

The Commission specifically requests comments on the assumptions used to determine the approximate additional costs of the proposed new requirements.

The Commission proposes amendments to §3.13 under Texas Water Code, §26.131, which gives the Commission jurisdiction over pollution of surface or subsurface waters from oil and gas exploration, development, and production activities; Texas Water Code, Chapter 27, which authorizes the Commission to adopt and enforce rules relating to injection wells; Texas Natural Resources Code, §81.052, which authorizes the Commission to adopt all necessary rules for governing persons and their operations under the jurisdiction of the Commission under Texas Natural Resources Code, §81.051; Texas Natural Resources Code, §85.201, which authorizes the Commission to make and enforce rules for the conservation of oil and gas and prevention of waste of oil and gas; Texas Natural Resources Code, §85.202, which authorizes the Commission to adopt rules to prevent waste of oil and gas in producing operations; Texas Natural Resources Code, §91.101, which authorizes the Commission to adopt rules relating to the various oilfield operations, including the discharge, storage, handling, transportation, reclamation, or disposal of oil and gas waste; and Texas Natural Resources Code §91.602, which authorizes the Commission to adopt and enforce rules relating to the generation, transportation, treatment, storage, and disposal of oil and gas hazardous waste.

Texas Water Code, §26.131; Chapter 27; and Texas Natural Resources Code, §§81.052, 85.042(b), 85.201, 85.202, 91.101, and 91.602 are affected by the proposed amendments.

Statutory authority: Texas Water Code, §26.131; Chapter 27; and Texas Natural Resources Code, §§81.052, 85.042(b), 85.201, 85.202, 91.101, and 91.602.

Cross-reference to statute: Texas Water Code, §26.131; Chapter 27; and Texas Natural Resources Code, §§81.052, 85.042(b), 85.201, 85.202, 91.101, and 91.602.

Issued in Austin, Texas on January 29, 2013.

§3.13. Casing, Cementing, Drilling, Well Control, and Completion Requirements.

(a) General.

(1) Intent. The operator is responsible for compliance with this section during all operations at the well. It is the intent of all provisions of this section that casing be securely anchored in the hole in order to effectively control the well at all times, all usable-quality water zones be isolated and sealed off to effectively prevent contamination or harm, and all [~~potentially~~] productive zones, potential flow zones, and zones with corrosive formation fluids be isolated and sealed off to prevent vertical migration of fluids or gases behind the casing. When the section does not detail specific methods to achieve these objectives, the responsible party shall make every effort to follow the intent of the section, using good engineering practices and the best currently available technology.

(2) Definitions. The following words and terms, when used in this section [~~chapter~~], shall have the following meanings, unless the context clearly indicates otherwise.

(A) Stand under pressure--To leave the hydrostatic column pressure in the well acting as the natural force without adding any external pump pressure. The provisions are complied with if a float collar and/or float shoe is used and found to be holding at the completion of the cement job.

(B) Zone of critical cement--

(i) For surface casing strings, [~~shall be~~] the bottom 20% of the casing string, but [~~shall be~~] no more than 1,000 feet nor less than 300 feet. The zone of critical cement extends to the land surface for surface casing strings of 300 feet or less.

(ii) For intermediate or production casing strings, the bottom 20% of the casing string or not less than 300 vertical feet above the casing shoe or top of the highest proposed productive zone.

(C) Protection depth--Depth to which usable-quality water must be protected, as determined by the Groundwater Advisory Unit of the Oil and Gas Division [~~Texas Commission on Environmental Quality (TCEQ) or its successor agencies~~], which may include zones that contain brackish or saltwater if such zones are correlative and/or hydrologically connected to zones that contain usable-quality water.

(D) Productive zone [~~horizon~~]--Any stratum known to contain oil, gas, or geothermal resources in commercial quantities in the area.

(E) Associated gas zone--A zone in an oil well in which natural gas, commonly known as gas cap gas, overlies and is in contact with crude oil in a reservoir.

(F) Bay well--Any well under the jurisdiction of the Commission for which the surface location is either:

(i) located in or on a lake, river, stream, canal, estuary, bayou, or other inland navigable waters of the state and which requires plugging by means other than conventional land-based methods, including, but not limited to, use of a barge, use of a boat, dredging,

or building a causeway or other access road to bring in the necessary equipment to plug the well; or

(ii) located on state lands seaward of the mean high tide line of the Gulf of Mexico in water of a depth at mean high tide of not more than 100 feet that is sheltered from the direct action of the open seas of the Gulf of Mexico.

(G) Deputy director of Field Operations--The deputy director of Field Operations of the Oil and Gas Division or the deputy director's delegate.

(H) Director--The director of the Oil and Gas Division of the Railroad Commission of Texas or the director's delegate.

(I) District director--The Director of a Railroad Commission district office or the district director's delegate.

(J) Hydraulic fracturing treatment--A completion process involving treatment of a well by the application of hydraulic fracturing fluid under pressure for the express purpose of initiating and/or propagating fractures in a target geologic formation to enhance production of oil and/or natural gas.

(K) Land well--Any well subject to Commission jurisdiction for which the surface location is not in or on inland or coastal waters.

(L) Minimum separation well--A well in which hydraulic fracturing treatments will be conducted and for which:

(i) the vertical distance between the base of usable quality water and the top of the formation to be stimulated is less than 1,000 vertical feet;

(ii) the director has determined contains inadequate separation between the base of usable quality water and the top of the formation in which hydraulic fracturing treatments will be conducted; or

(iii) the director has determined is in a structurally complex geologic setting.

(M) Offshore well--Any well subject to Commission jurisdiction for which the surface location is on state lands in or on the Gulf of Mexico, that is not a bay well.

(N) Potential flow zone--A zone designated by the director or identified by the operator using available data that needs to be isolated to prevent sustained pressurization of the surface casing/intermediate casing or production casing annulus sufficient to cause damage to casing and/or cement in a well such that it presents a threat to subsurface water or other subsurface resources, or sufficient to cause the fluids in the annulus to maintain a static fluid level at or less than 250 vertical feet below the protection depth.

(O) Zone with corrosive formation fluids--Any zone containing formation fluids that are capable of negatively impacting the integrity of casing and/or cement or have a demonstrated trend of failure for similar casing and cement design in the field.

(3) Wellbore diameters.

(A) The diameter of the wellbore in which surface casing will be set and cemented shall be at least one and one-half (1.50) inches greater than the nominal outside diameter of casing to be installed, unless otherwise approved by the district director.

(B) For subsequent casing strings, the diameter of each section of the wellbore for which casing will be set and cemented shall be at least one (1) inch greater than the nominal outside diameter of the casing to be installed, unless otherwise approved by the district director.

(C) The casing diameter requirements in subparagraphs (A) and (B) of this paragraph do not apply to reentries, liners, and expandable casing.

(D) The wellbore diameter shall be consistent with manufacturer's recommendations for all float equipment; centralizers, packers, cement baskets, and all other equipment run into the wellbore on casing.

(4) Casing and cementing.

(A) All casing cemented in any well shall be steel casing that has been hydrostatically pressure tested with an applied pressure at least equal to the maximum pressure to which the pipe will be subjected in the well. For new pipe, the mill test pressure may be used to fulfill this requirement. As an alternative to hydrostatic testing, a casing evaluation tool may be employed. Casing meeting the performance standards set forth in API Specification 5CT: Specification for Casing and Tubing (or a Commission-approved equivalent standard) shall be used through the protection depth.

(B) Cement shall meet the standards set forth in API Specification 10A: Specification for Cement and Material for Well Cementing or the American Society for Testing and Materials (ASTM) Specification C150/C150M, Standard Specification for Portland Cement (or a Commission-approved equivalent standard).

(C) Casing shall be cemented across and above all formations permitted for injection under §3.9 of this title (relating to Disposal Wells), or §3.46 of this title (relating to Fluid Injection into Productive Reservoirs), within one-quarter mile of the proposed well location, in the following manner:

(i) If the top of cement is determined through calculation, across and extending at least 600 feet (measured depth) above the permitted formations;

(ii) If the top of cement is determined through the performance of a temperature survey, across and extending 250 feet (measured depth) above the permitted formations;

(iii) if the top of cement is determined through the performance of a cement evaluation log, across and extending 100 feet (measured depth) above the permitted formations;

(iv) across and extending at least 200 feet into the previous casing shoe (or to surface if the shoe is less than 200 feet from the surface); or

(v) as otherwise approved by the district director.

(D) Casing shall be cemented across and above all productive zones, potential flow zones, and/or zones with corrosive formation fluids, in the following manner:

(i) If the top of cement is determined through calculation, across and extending at least 600 feet (measured depth) above the zones;

(ii) If the top of cement is determined through the performance of a temperature survey, across and extending 250 feet (measured depth) above the zones;

(iii) if the top of cement is determined through the performance of a cement evaluation log, across and extending 100 feet (measured depth) above the zones;

(iv) across and extending at least 200 feet into the previous casing shoe (or to the surface if the shoe is less than 200 feet from the surface); or

(v) as otherwise approved by the district director.

(E) Where necessary, the cement slurry shall be designed to control annular gas migration consistent with, or equivalent to, the standards in API Standard 65-Part 2: Isolating Potential Flow Zones During Well Construction.

(5) Casing testing before drillout. For surface and intermediate strings of casing, before drilling the cement plug, the operator shall test the casing at a pump pressure in pounds per square inch (psi) calculated by multiplying the length of the true vertical depth in feet of the casing string by a factor of 0.5 psi per foot. The maximum test pressure required, however, unless otherwise ordered by the commission, need not exceed 1,500 psi. If, at the end of 30 minutes, the pressure shows a drop of 10% or more from the original test pressure, the casing shall be condemned until the leak is corrected. A pressure test demonstrating less than a 10% pressure drop after 30 minutes constitutes confirmation that the condition has been corrected. The operator shall notify the district director of a failed test. In the event of a pressure test failure, completion operations may not re-commence until the district director approves a remediation plan, the operator successfully implements the plan, and the operator conducts a successful pressure test.

(6) Well control.

(A) Wellhead assemblies. After setting the conductor pipe and/or surface casing, wellhead assemblies shall be used on wells to maintain surface control of the well at all times. Each component of the wellhead shall have a pressure rating equal to or greater than the anticipated pressure to which that particular component might be exposed during the course of drilling, testing, or producing the well.

(B) Well control equipment.

(i) An operator shall install a blowout preventer system or control head and other connections to keep the well under control at all times as soon as surface casing is set. When conductor casing is set and/or shallow gas is anticipated to be encountered, operators shall install a diverter system on the conductor casing. For bay and offshore wells, at a minimum, such systems shall include a double ram blowout preventer, including pipe and blind rams, an annular-type blowout preventer or other equivalent control system, and a shear ram.

(ii) For wells in areas with hydrogen sulfide, the operator shall comply with §3.36 of this title (relating to Oil, Gas, or Geothermal Resource Operation in Hydrogen Sulfide Areas).

(iii) Ram type blowout prevention equipment shall have a rated working pressure that equals or exceeds the maximum anticipated surface pressure of the well. Blowout preventer rams shall be of a proper size for the drill pipe being used or production casing being run in the well or shall be variable-type rams that are in the appropriate size range.

(iv) Controls shall be accessible on the rig floor or at a safe remote location.

(v) Operators shall install a drill pipe safety valve to close off the drill pipe to prevent backflow of water, oil, gas, or other formation fluids into the wellbore during drilling.

(vi) Operators shall install a choke line of the sufficient size and working pressure.

(vii) When using a Kelly rig during drilling, the well shall be fitted with an upper Kelly cock in proper working order to close in the drill string below hose and swivel, when necessary for well control. A lower Kelly safety valve shall be installed so that it can be run through the blowout preventer. When needed for well control, the operator shall maintain at all times on the rig floor safety valves to include:

(I) full-opening safety valve; and

(II) inside blowout preventer valve with wrenches, handling tools, and necessary subs for all drilling pipe sizes in use.

(viii) All control equipment shall be consistent with API Standard 53: Recommended Practices for Blowout Prevention Equipment Systems for Drilling Wells. Control equipment shall be certified in accordance with API Standard 53 as operable under the product manufacturer's minimum operational specifications. Certification shall include the proper operation of the closing unit valving, the pressure gauges, and the manufacturer's recommended accumulator fluids. Certification shall be obtained through an independent company that tests blowout preventers, stacks and casings. Certification shall be performed every five (5) years and the proof of certification shall be made available upon request of the Commission.

(ix) All control equipment shall be in good working condition at all times. All outlets, fittings, and connections on the casing, blowout preventers, choke manifold, and auxiliary wellhead equipment that may be subjected to wellhead pressure shall be of a material and construction to withstand or exceed the anticipated pressure. The lines from outlets on or below the blowout preventers shall be securely installed, anchored, and protected from damage.

(x) In addition to the primary closing system, including an accumulator system, the blowout preventers shall have a secondary mode of closure at a remote location.

(xi) Testing of blowout prevention equipment.

(I) Ram type blowout prevention equipment shall be tested to at least the maximum anticipated surface pressure of the well, but not less than 1,500 psi, before drilling the plug on the surface casing and before encountering any high-pressure formations.

(II) Blowout prevention equipment shall be tested upon installation, after the disconnection or repair of any pressure containment seal in the blowout preventer stack, choke line, or choke manifold, limited to the affected component, with testing to occur at least every 21 days. When requested, the district director shall be notified before the commencement of a test.

(III) A record of each test, including test pressures, times, failures, and each mechanical test of the casings, blowout preventers, surface connections, surface fittings, and auxiliary wellhead equipment shall be entered in the logbook, signed by the person responsible for the test, and made available for inspection by the commission upon request.

(C) Drilling fluid program.

(i) The characteristics, use, and testing of drilling fluid and conduct of related drilling procedures shall be designed to prevent the blowout of any well. Adequate supplies of drilling fluid of sufficient weight and other acceptable characteristics shall be maintained. Drilling fluid tests shall be performed as needed to ensure well control. Adequate drilling fluid testing equipment shall be kept on the drilling location at all times. The hole shall be filled with sufficient drilling fluid to maintain well control at all times. When pulling drill pipe, the drilling fluid volume required to fill the hole each time shall be measured to assure that it corresponds with the displacement of pipe pulled. Mud pit levels shall be monitored during the drilling process. Mud-gas separation equipment shall be installed and operated as needed when abnormally pressured gas-bearing formations may be encountered. The commission shall have access to the drilling fluid records and shall be allowed to conduct any essential tests on the drilling fluid used in the drilling or recompletion of a well. When the conditions and

tests indicate a need for a change in the drilling fluid program in order to insure control of the well, the operator shall use due diligence in modifying the program.

(ii) Wells drilled with air shall maintain well control using blowout preventer systems and/or diverter systems.

(iii) All hole intervals drilled prior to reaching the base of protected water shall be drilled with air, fresh water or a fresh water based drilling fluid. No oil-based drilling fluid may be used until casing has been set and cemented to the protection depth.

(D) Diverter systems for bay and offshore wells. Any bay or offshore well that is drilled to and/or through formations where the expected reservoir pressure exceeds the hydrostatic pressure of the drilling fluid column shall be equipped to divert any wellbore fluids away from the rig floor. When the diverter system is installed, the diverter components including the sealing element, diverter valves, control systems, stations and vent lines shall be function and pressure tested. For drilling operations with a surface wellhead configuration, the system shall be function tested at least once every 24-hour period after the initial test. After all connections have been made on the surface casing or conductor casing, the diverter sealing element and diverter valves shall be pressure tested to a minimum of 200 psig. Subsequent pressure tests shall be conducted within seven days after the previous test. All diverter systems shall be maintained in working condition. No operator shall continue drilling operations if a test or other information indicates that the diverter system is unable to function or operate as designed.

(E) Casinghead.

(i) Requirements. All land and bay wells shall be equipped with casingheads of sufficient rated working pressure, with adequate connections and valves accessible at the surface, to allow pumping of fluid between any two strings of casing at the surface.

(ii) Casinghead test procedure. Any well showing sustained pressure on the casinghead, or leaking gas or oil between the surface casing and the next casing string, shall be tested in the following manner. The well shall be killed with water or mud and pump pressure applied. The casing shall be condemned if the pressure gauge on the casinghead reflects the applied pressure. After completing corrective measures, the casing shall be tested in the same manner. This method shall be used when the origin of the pressure cannot otherwise be determined.

(F) Christmas tree.

(i) All completed non-pumping wells shall be equipped with Christmas tree fittings and wellhead connections with a rated working pressure equal to, or greater than, the surface shut-in pressure of the well. The tubing shall be equipped with a master valve, but two master valves shall be used on all wells with surface pressures in excess of 5,000 psi. All wellhead connections shall be assembled and tested prior to installation by a fluid pressure equal to the test pressure of the fitting employed.

(ii) The Christmas tree for completed bay and offshore wells shall be equipped with either two master valves, one master valve and one wing valve, or two wing valves. All bay and offshore wells shall have at least five feet of spacing between the bottom of the Christmas tree and the surface of the water at high tide, where applicable. Any newly completed bay and offshore well or existing well on which the Christmas tree is being replaced shall be equipped with a back pressure valve wellhead profile at the flange where the tubing hangs on the Christmas tree.

(G) Storm choke and safety valve.

(i) Bay and offshore wells shall be equipped with a storm choke and/or safety valve installed in the tubing.

(ii) An operator may request approval to use a surface safety valve in lieu of a subsurface safety valve by filing with the appropriate district director a written request for such approval providing all pertinent information to support the exception.

(iii) The depth and type of the safety valve shall be reported in the "remarks" section of the appropriate completion report form required by §3.16 of this title (relating to Log and Completion or Plugging Report), after the well is completed or recompleted.

(7) Additional requirements for wells on which hydraulic fracturing treatments will be conducted.

(A) All casing installed in a well that will be subjected to hydraulic fracturing treatments shall have a minimum internal yield pressure rating of at least 1.15 times the maximum pressure to which the casing may be subjected.

(B) The operator shall pressure test the casing (or fracture tubing) on which the pressure will be exerted during hydraulic fracturing treatments to at least the maximum anticipated pressure. The district director shall be notified of a failed test within 24 hours of completion of the test. No hydraulic fracturing treatment may be conducted until the district director has approved a remediation plan, and the operator has implemented the approved remediation plan and successfully re-tested the casing (or fracture tubing).

(C) During hydraulic fracturing treatment operations, the operator shall monitor all annuli. The operator shall immediately suspend hydraulic fracturing treatment operations if the pressures deviates above those anticipated increases caused by pressure or thermal transfer and shall notify the appropriate district director within 24 hours of such deviation. Further completion operations, including hydraulic fracturing treatment operations, may not recommence until the district director approves a remediation plan and the operator successfully implements the approved plan.

(D) The following conditions also apply if the well is a minimum separation well, unless otherwise approved by the director:

(i) Cementing of the production casing in a minimum separation well shall be by the pump and plug method. The production casing shall be cemented from the shoe up to a point at least 200 feet (measured depth) above the shoe of the next shallower casing string that was set and cemented in the well (or to surface if the shoe is less than 200 feet from the surface).

(ii) The operator shall pressure test the casing string on which the pressure will be exerted during stimulation to the maximum pressure that will be exerted during hydraulic fracturing treatment. The operator shall notify the district director within 24 hours of a failed test. No hydraulic fracturing treatment may be conducted until the district director has approved a remediation plan, and the operator has implemented the approved remediation plan and successfully re-tested the casing (or fracture tubing).

(iii) The production casing for any minimum separation well shall not be disturbed for a minimum of eight hours after cement is in place and casing is hung-off, and in no case shall the casing be disturbed until the cement has reached a minimum compressive strength of 500 psi.

(iv) In addition to conducting an evaluation of cementing records and annular pressure monitoring results, the operator of a minimum separation well shall run a cement evaluation tool to assess radial cement integrity and placement behind the production casing. If the cement evaluation indicates insufficient isolation, com-

pletion operations may not re-commence until the district director approves a remediation plan and the operator successfully implements the approved plan.

(v) The operator of a minimum separation well may request from the appropriate district director approval of an exemption from the requirement to run a cement evaluation tool. Such request shall include information demonstrating that the operator has:

(I) successfully set, cemented, and tested the casing for which the exemption is requested in at least five minimum separation wells by the same operator in the same operating field;

(II) obtained cement evaluation tool logs that support the findings of cementing records, annular pressure monitoring results or other tests demonstrating that successful cement placement was achieved to isolate productive zones, potential flow zones, and/or zones with corrosive formation fluids; and

(III) shown that the well for which the exemption is requested will be constructed and cemented using the same or similar techniques, methods, and cement formulation used in the five wells that have had successful cement jobs.

(8) Pipeline shut-off valves for bay and offshore wells. All bay and offshore gathering pipelines designed to transport oil, gas, condensate, or other oil or geothermal resource field fluids from a well or platform shall be equipped with automatically controlled shut-off valves at critical points in the pipeline system. Other safety equipment shall be in full working order as a safeguard against spillage from pipeline ruptures.

(9) Training for bay and offshore wells. All tool pushers, drilling superintendents, and operators' representatives (when the operator is in control of the drilling) shall be required to, upon request, furnish certification of satisfactory completion of an American Petroleum Institute (API) training program, an International Association of Drilling Contractors (IADC) training program, or other equivalent nationally recognized training program on well control equipment and procedures. The certification shall be renewed every two years by attending an API- or IADC-approved refresher course or a refresher course approved by the equivalent nationally recognized training program.

(10) Bottom-hole pressure surveys. The commission may require bottom-hole pressure surveys of the various fields at such times as determined to be necessary. However, operators shall be required to take bottom-hole pressures only in those wells that are not likely to suffer damaging effects from the survey. Tubing and tubingheads shall be free from obstructions in wells used for bottom-hole pressure test purposes.

(b) Casing and cementing requirements for land wells and bay wells. [~~Onshore and inland waters.~~]

[~~(1) General.~~]

[~~(A) All casing cemented in any well shall be steel casing that has been hydrostatically pressure tested with an applied pressure at least equal to the maximum pressure to which the pipe will be subjected in the well. For new pipe, the mill test pressure may be used to fulfill this requirement. As an alternative to hydrostatic testing, a full length electromagnet, ultrasonic, radiation thickness gauging, or magnetic particle inspection may be employed.~~]

[~~(B) Wellhead assemblies shall be used on wells to maintain surface control of the well. Each component of the wellhead shall have a pressure rating equal to or greater than the anticipated pressure to which that particular component might be exposed during the course of drilling, testing, or producing the well.~~]

[~~(C) A blowout preventer or control head and other connections to keep the well under control at all times shall be installed as soon as surface casing is set. This equipment shall be of such construction and capable of such operation as to satisfy any reasonable test which may be required by the commission or its duly accredited agent.~~]

[~~(D) When cementing any string of casing more than 200 feet long, before drilling the cement plug the operator shall test the casing at a pump pressure in pounds per square inch (psi) calculated by multiplying the length of the casing string by 0.2. The maximum test pressure required, however, unless otherwise ordered by the commission, need not exceed 1,500 psi. If, at the end of 30 minutes, the pressure shows a drop of 10% or more from the original test pressure, the casing shall be condemned until the leak is corrected. A pressure test demonstrating less than a 10% pressure drop after 30 minutes is proof that the condition has been corrected.~~]

[~~(E) Wells drilling to formations where the expected reservoir pressure exceeds the weight of the drilling fluid column shall be equipped to divert any wellbore fluids away from the rig floor. All diverter systems shall be maintained in an effective working condition. No well shall continue drilling operations if a test or other information indicates the diverter system is unable to function or operate as designed.~~]

(1) [~~(2)~~] Surface casing requirements for land wells and bay wells.

(A) Any proposal to set surface casing to a depth of 3,500 feet or greater shall require prior approval of the appropriate district director. A request for such approval shall be in writing and shall specify how the operator plans to maintain well control during drilling, and ensure successful circulation and adequate bonding of cement, and, if necessary, prevent upward migration of deeper formation fluids into protected water. The district director may grant approvals on an area basis.

(B) [~~(A)~~] Amount required.

(i) An operator shall set and cement sufficient surface casing to protect all usable-quality water strata, as defined by the Groundwater Advisory Unit of the Oil and Gas Division [~~TCEQ~~]. Unless surface casing requirements are specified in field rules approved prior to the effective date of this rule, before [~~Before~~] drilling any well [~~in any field or area in which no field rules are in effect or in which surface casing requirements are not specified in the applicable field rules~~], an operator shall obtain a letter from the Groundwater Advisory Unit of the Oil and Gas Division [~~TCEQ~~] stating the protection depth. In no case, however, is surface casing to be set deeper than 200 feet below the specified depth without prior approval from the district director [~~commission~~]. The district director may grant such approval on an area basis.

(ii) Any well drilled to a total depth of 1,000 feet or less below the ground surface may be drilled without setting surface casing provided no shallow gas sands or abnormally high pressures are known to exist at depths shallower than 1,000 feet below the ground surface; and further, provided that production casing is cemented from the shoe to the ground surface by the pump and plug method.

(C) [~~(B)~~] Cementing. Cementing shall be by the pump and plug method. Sufficient cement shall be used to fill the annular space outside the casing from the shoe to the ground surface or to the bottom of the cellar. If cement does not circulate to ground surface or the bottom of the cellar, the operator or the operator's [~~his~~] representative shall obtain the approval of the district director for the procedures to be used to perform additional cementing operations, if needed, to cement surface casing from the top of the cement to the ground surface.

(D) [~~(C)~~] Cement quality.

(i) Surface casing strings must be allowed to stand under pressure until the cement has reached a compressive strength of at least 500 psi in the zone of critical cement before drilling plug or initiating a test. The cement mixture in the zone of critical cement shall have a 72-hour compressive strength of at least 1,200 psi.

(ii) An operator may use cement with volume extenders above the zone of critical cement to cement the casing from that point to the ground surface, but in no case shall the cement have a compressive strength of less than 100 psi at the time of drill out nor less than 250 psi 24 hours after being placed.

(iii) In addition to the minimum compressive strength of the cement, the free water content shall be minimized to the greatest extent practicable in the cement slurry to be used in the zone of critical cement. In no event shall the [~~API~~] free water separation [~~shall~~] average [~~no~~] more than two milliliters [~~six milliliters~~] per 250 milliliters of cement tested in accordance with the current API RP 10B-2: Recommended Practice for Testing Well Cements, inside the zone of critical cement, or more than six milliliters per 250 milliliters of cement tested outside the zone of critical cement [~~10B~~].

(iv) The commission may require a better quality of cement mixture to be used in any well or any area if [~~evidence of local~~] conditions indicate that [~~indicates~~] a better quality of cement is necessary to prevent pollution, isolate productive zones, potential flow zones, or zones with corrosive formation fluids or prevent a safety issue in the well [~~or to provide safer conditions in the well or area~~].

(E) [~~(D)~~] Compressive strength tests. Cement mixtures for which published performance data are not available must be tested by the operator or service company. Tests shall be made on representative samples of the basic mixture of cement and additives used, using distilled water or potable tap water for preparing the slurry. The tests must be conducted using the equipment and procedures in, or equipment and procedures equivalent to those in, API RP 10B-2, Recommended Practice for Testing Well Cements [~~adopted by the American Petroleum Institute, as published in the current API RP 10B~~]. Test data showing competency of a proposed cement mixture to meet the above requirements must be furnished to the commission prior to the cementing operation. To determine that the minimum compressive strength has been obtained, operators shall use the typical performance data for the particular cement used in the well (containing all the additives, including any accelerators used in the slurry) at the following temperatures and at atmospheric pressure.

(i) For the cement in the zone of critical cement, the test temperature shall be within 10 degrees Fahrenheit of the formation equilibrium temperature at the top of the zone of critical cement.

(ii) For the filler cement, the test temperature shall be the temperature found 100 feet below the ground surface level, or 60 degrees Fahrenheit, whichever is greater.

(F) [~~(E)~~] Cementing report. Within 30 days of [~~Upon~~] completion of the well, or within 90 days of cessation of drilling operations, whichever is earlier, a cementing report must be filed with the commission furnishing complete data concerning the cementing of surface casing in the well as specified on a form furnished by the commission. The operator of the well or the operator's [~~his~~] duly authorized agent having personal knowledge of the facts, and representatives of the cementing company performing the cementing job, must sign the form attesting to compliance with the cementing requirements of the commission.

(G) [~~(F)~~] Centralizers. Surface casing shall be centralized at the shoe, above and below a stage collar or diverting tool, if run, and through usable-quality water zones. In nondeviated holes, pipe centralization as follows is required: a centralizer shall be placed every fourth joint from the cement shoe to the ground surface or to the bottom of the cellar. All centralizers shall meet specifications in, or equivalent to, API spec 10D Specifications for Bow-Spring Casing Centralizers; API Spec 10 TR4, Technical Report on Considerations Regarding Selection of Centralizers for Primary Cementing Operations; and API RP 10D-2, Recommended Practice for Centralizer Placement and Stop Collar Testing [~~specifications~~]. In deviated holes, the operator shall provide additional centralization.

(H) [~~(G)~~] Alternative surface casing programs.

(i) An alternative method of fresh water protection may be approved upon written application to the appropriate district director. The operator shall state the reason [~~(economics, well control, etc.)~~] for the alternative fresh water protection method and outline the alternate program for casing and cementing through the protection depth for strata containing usable-quality water. Alternative programs for setting more than specified amounts of surface casing for well control purposes may be requested on a field or area basis. Alternative programs for setting less than specified amounts of surface casing will be considered [~~authorized~~] on an individual well basis only. The district director may approve, modify, or reject the proposed program. The district director shall deny the request if the operator has not demonstrated that the alternative casing plan will achieve the intent of this rule as described in subsection (a)(1) of this section. If the proposal is modified or rejected, the operator may request a review by the deputy director of field operations. If the proposal is not approved administratively, the operator may request a public hearing. An operator shall obtain approval of any alternative program before commencing operations.

(ii) Any alternate casing program shall require the first string of casing set through the protection depth to be cemented in a manner that will effectively prevent the migration of any fluid to or from any stratum exposed to the wellbore outside this string of casing. The casing shall be cemented from the shoe to ground surface in a single stage, if feasible, or by a multi-stage process with the stage tool set at least 100 [~~50~~] feet below the protection depth.

(iii) Any alternate casing program shall include pumping sufficient cement to fill the annular space from the shoe or multi-stage tool to the ground surface. If cement is not circulated to the ground surface or the bottom of the cellar, the operator shall run a temperature survey or cement bond log. The appropriate district office shall be notified prior to running the required temperature survey or bond log. After the top of cement outside the casing is determined, the operator or the operator's [~~his~~] representative shall contact the appropriate district director and obtain approval for the procedures to be used to perform any required additional cementing operations. Upon completion of the well, a cementing report shall be filed with the commission on the prescribed form.

(iv) Before parallel (nonconcentric) strings of pipe are cemented in a well, surface or intermediate casing must be set and cemented through the protection depth.

(I) Mechanical integrity test of surface casing after drillout.

(i) If the surface casing is exposed to more than 360 rotating hours after reaching total depth or the depth of the next casing string, the operator shall verify the integrity of the surface casing by using a casing evaluation tool or conducting a mechanical integrity test or equivalent Commission-approved casing evaluation method, unless otherwise approved by the district director.

(ii) If a mechanical integrity test is conducted, the appropriate district office shall be notified at least eight hours before the test is conducted to give the district office an opportunity to witness the test. The operator shall use a chart of acceptable range (20% - 80% of full scale) or an electronic equivalent approved by the district director, and the surface casing shall be tested at a pump pressure in pounds per square inch (psi) calculated by multiplying the length of the true vertical depth in feet of the casing string by a factor of 0.5 psi per foot up to a maximum of 1,500 psi for a minimum of 30 minutes. A pressure test demonstrating less than a 10% pressure drop after 30 minutes constitutes confirmation of an acceptable pressure test. The appropriate district office shall be notified within 24 hours after a failed test. Completion operations may not re-commence until the district director approves a remediation plan and the operator successfully implements the approved plan, and successfully re-tests the surface casing.

(2) [~~(3)~~] Intermediate casing requirements for land wells and bay wells.

(A) Cementing method. Each intermediate string of casing shall be cemented from the shoe to a point at least 600 feet (measured depth) above the shoe. If any productive zone, potential flow zone, or zone with corrosive formation fluids [~~horizon~~] is open to the wellbore above the casing shoe, the casing shall be cemented;

(i) if the top of cement is determined through calculation, from the shoe up to a point at least 600 feet (measured depth) above the top of the shallowest productive zone, potential flow zone, or zone with corrosive formation fluids; [~~horizon or~~]

(ii) if the top of cement is determined through performance of a temperature survey, from the shoe up to a point at least 250 feet (measured depth) above the top of the shallowest productive zone, potential flow zone, or zone with corrosive formation fluids;

(iii) if the top of cement is determined through performance of a cement evaluation log, from the shoe up to a point at least 100 feet (measured depth) above the top of the shallowest productive zone, potential flow zone, or zone with corrosive formation fluid; or

(iv) to a point at least 200 feet (measured depth) above the shoe of the next shallower casing string that was set and cemented in the well (or to surface if the shoe is less than 200 feet from the surface); or[~~.~~]

(v) as otherwise approved by the district director.

(B) Top of cement. The calculated or measured top of cement shall be indicated on the appropriate completion form required by §3.16 of this title (relating to Log and Completion or Plugging Report).

(C) [~~(B)~~] Alternate method. In the event the distance from the casing shoe to the top of the shallowest productive zone, potential flow zone, and/or zone with corrosive formation fluids [~~horizon~~] make cementing, as specified above, impossible or impractical, the multi-stage process may be used to cement the casing in a manner that will effectively isolate and seal the zones to [~~off all such possible productive horizons and~~] prevent fluid migration to or from such strata within the wellbore.

(3) [~~(4)~~] Production casing requirements for land wells and bay wells.

(A) Centralizers. In deviated and horizontal holes, the operator shall provide additional centralization as necessary to ensure zonal isolation between the top of the interval to be completed and the shallower zones that require isolation.

(B) [~~(A)~~] Cementing method. The production [~~producing~~] string of casing shall be cemented by the pump and plug method, or another method approved by the commission, with sufficient cement to fill the annular space back of the casing to the surface or to a point at least 600 feet above the shoe. If any productive zone, potential flow zone and/or zone with corrosive formation fluids [~~horizon~~] is open to the wellbore above the casing shoe, the casing shall be cemented in a manner that effectively seals off all such zones [~~possibly productive horizons~~] by one of the methods specified for intermediate casing in paragraph (2) [~~(3)~~] of this subsection. A float collar or other means to stop the cement plug shall be inserted in the casing string above the shoe. Cement shall be allowed to stand under pressure for a minimum of eight hours before drilling the plug or initiating tests. In the event that the distance from the casing shoe to the top of the shallowest productive zone, potential flow zone and/or zone with corrosive formation fluids make cementing, as required above, impossible or impractical, the multi-stage process may be used to cement the casing in a manner that will effectively seal off all such zones, and prevent fluid migration to or from such zones within the wellbore. Uncemented casing is allowable within a producing reservoir provided the production casing is cemented in such a manner to effectively isolate and seal off that zone from all other productive zones in the wellbore as required by §3.7 of this title (relating to Strata To Be Sealed Off).

(C) Reporting of top of cement. Calculated or measured top of cement shall be indicated on the appropriate completion form required by §3.16 of this title.

(D) [~~(B)~~] Isolation of associated gas zones. The position of the gas-oil contact shall be determined by coring, electric log, or testing. The producing string shall be landed and cemented below the gas-oil contact, or set completely through and perforated in the oil-saturated portion of the reservoir below the gas-oil contact.

(4) [~~(5)~~] Tubing [~~and storm choke~~] requirements for land wells and bay wells.

(A) Tubing requirements for oil wells. All flowing oil wells shall be equipped with and produced through tubing. When tubing is run inside casing in any flowing oil well, the bottom of the tubing shall be at a point not higher than 100 feet (vertical depth) above the top of the producing interval nor more than 50 feet (vertical depth) above the top of the liner [~~a line~~], if a liner [~~one~~] is used, or 100 feet (vertical depth) above the kickoff point in a deviated or horizontal well. In a multiple zone structure, however, when an operator elects to equip a well in such a manner that small through-the-tubing type tools may be used to perforate, complete, plug back, or recomplete without the necessity of removing the installed tubing, the bottom of the tubing may be set at a distance up to, but not exceeding, 1,000 feet (vertical depth) above the top of the perforated or open-hole interval actually open for production into the wellbore. [~~In no case shall tubing be set at a depth of less than 70% of the distance from the surface of the ground to the top of the interval actually open to production.~~]

(B) Alternate tubing requirements. Alternate programs requesting a temporary exception pursuant to subsection (d) of this section to omit tubing from a flowing oil well may be authorized on an individual well basis by the appropriate district director. The district director shall deny the request if the operator has not demonstrated that the alternative tubing plan will achieve the intent as described in subsection (a)(1) of this section. If the proposal is rejected, the operator may request a review by the director of field operations. If the proposal is not approved administratively, the operator may request a hearing. An operator shall obtain approval of any alternative program before commencing operations.

[~~(B) Storm choke. All flowing oil, gas, and geothermal resource wells located in bays, estuaries, lakes, rivers, or streams must be equipped with a storm choke or similar safety device installed in the tubing a minimum of 100 feet below the mud line.~~]

(c) Casing, cementing, drilling, and completion requirements for offshore wells [~~Texas offshore casing, cementing, drilling, and completion requirements~~].

(1) Casing. An offshore well shall be cased with [~~The casing program shall include~~] at least three strings of pipe, in addition to such drive pipe as the operator may desire, which shall be set in accordance with the following program.

(A) Conductor casing. A string of new pipe, or reconditioned pipe with substantially the same characteristics as new pipe, shall be set and cemented at a depth of not less than 300 feet TVD (true vertical depth) nor more than 800 feet TVD below the mud line. Sufficient cement shall be used to fill the annular space back of the pipe to the mud line; however, cement may be washed out or displaced to a maximum depth of 50 feet below the mud line to facilitate pipe removal on abandonment. Casing shall be set and cemented in all cases prior to penetration of known shallow oil and gas formations, or upon encountering such formations.

(B) Surface casing. All surface casing shall be a string of new pipe with a mill test of at least 1,100 pounds per square inch (psi) or reconditioned pipe that has been tested to an equal pressure. Sufficient cement shall be used to fill the annular space behind the pipe to the mud line; however, cement may be washed out or displaced to a maximum depth of 50 feet below the mud line to facilitate pipe removal on abandonment. Surface casing shall be set and cemented in all cases prior to penetration of known shallow oil and gas formations, or upon encountering such formations. In all cases, surface casing shall be set prior to drilling below 3,500 feet TVD. Minimum depths for surface casing are as follows.

(i) Surface Casing Depth Table.

Figure: 16 TAC §3.13(c)(1)(B)(i)

(ii) Surface Casing test.

(I) Cement shall be allowed to stand under pressure for a minimum of eight hours before drilling plug or initiating tests. Casing shall be tested by pump pressure to at least 1,000 psi. If, at the end of 30 minutes, the pressure shows a drop of 100 psi or more, the casing shall be condemned until the leak is corrected. A pressure test demonstrating a drop of less than 100 psi after 30 minutes constitutes confirmation [~~is proof~~] that the condition has been corrected.

(II) After drillout, if the surface casing is exposed to more than 360 rotating hours, the operator shall verify the integrity of the casing using a casing evaluation tool, a mechanical integrity test, or an equivalent Commission-approved alternate casing evaluation methodology, unless otherwise approved by the district director.

(III) If a mechanical integrity test of the surface casing is conducted, the appropriate district office shall be notified a minimum of eight (8) hours before the test is conducted. The operator shall use a chart of acceptable range (20% - 80% of full scale) or an electronic equivalent approved by the district director, and the surface casing shall be tested at a minimum test pressure of 0.5 psi per foot multiplied by the true vertical depth of the surface casing up to a maximum of 1,500 psi for a minimum of 30 minutes. A pressure test demonstrating less than a 10% drop in pressure after 30 minutes constitutes confirmation of an acceptable pressure test. The operator shall notify the appropriate district office within 24 hours of a failed test. Completion operations may not re-commence until the district director approves a remediation plan and the operator implements the approved plan, and the operator successfully re-tests the surface casing.

(C) Production casing or oil string.

(i) The production casing or oil string shall be new or reconditioned pipe with a mill test of at least 2,000 psi that has been tested to an equal pressure.

(ii) After [~~and after~~] cementing, the production casing shall be tested by pump pressure to at least 1,500 psi. If, at the end of 30 minutes, the pressure shows a drop of 150 psi or more, the casing shall be condemned. After corrective operations, the casing shall again be tested in the same manner.

(iii) Cementing of the production casing shall be by the pump and plug method. Sufficient cement shall be used to fill the calculated annular space above the shoe to isolate [~~protect~~] any productive zones, potential flow zones, or zones with corrosive formation fluids [~~prospective producing horizons~~] and to a depth that isolates abnormal pressure from normal pressure (0.465 psi per vertical foot of gradient). A float collar or other means to stop the cement plug shall be inserted in the casing string above the shoe. Cement shall be allowed to stand under pressure for a minimum of eight hours before drilling the plug or initiating tests.

(2) Operators shall comply with the well control requirements of subsection (a)(6) of this section.

[~~(2) Blowout preventers.~~]

[~~(A) Before drilling below the conductor casing, the operator shall install at least one remotely controlled blowout preventer with a mechanism for automatically diverting the drilling fluid to the mud system when the blowout preventer is activated.~~]

[~~(B) After setting and cementing the surface casing, a minimum of two remotely controlled hydraulic ram-type blowout preventers (one equipped with blind rams and one with pipe rams), valves, and manifolds for circulating drilling fluid shall be installed for the purpose of controlling the well at all times. The ram-type blowout preventers, valves, and manifolds shall be tested to 100% of rated working pressure, and the annular-type blowout preventer shall be tested to 1,000 psi at the time of installation. During drilling and completion operations, the ram-type blowout preventers shall be tested by closing at least once each trip, and the annular-type preventer shall be tested by closing on drill pipe once each week.~~]

[~~(3) Kelly cock. During drilling, the well shall be fitted with an upper kelly cock in proper working order to close in the drill string below hose and swivel, when necessary for well control. A lower kelly safety valve shall be installed so that it can be run through the blowout preventer. When needed for well control, the operator shall maintain at all times on the rig floor safety valves to include:~~]

[~~(A) full-opening valve of similar design as the lower Kelly safety valves; and~~]

[~~(B) inside blowout preventer valve with wrenches, handling tools, and necessary subs for all drilling pipe sizes in use.~~]

[~~(4) Mud program. The characteristics, use, and testing of drilling mud and conduct of related drilling procedures shall be designed to prevent the blowout of any well. Adequate supplies of mud of sufficient weight and other acceptable characteristics shall be maintained. Mud tests shall be made frequently. Adequate mud testing equipment shall be kept on the drilling platform at all times. The hole shall be kept full of mud at all times. When pulling drill pipe, the mud volume required to fill the hole each time shall be measured to assure that it corresponds with the displacement of pipe pulled. A derrick floor~~

~~recording mud pit level indicator shall be installed and operative at all times. A careful watch for swabbing action shall be maintained when pulling out of hole. Mud-gas separation equipment shall be installed and operated.]~~

~~[(5) Casinghead.]~~

~~[(A) Requirement. All wells shall be equipped with casingheads of sufficient rated working pressure, with adequate connections and valves available, to permit pumping mud-laden fluid between any two strings of casing at the surface.]~~

~~[(B) Casinghead test procedure. Any well showing sustained pressure on the casinghead, or leaking gas or oil between the surface casing and the oil string, shall be tested in the following manner. The well shall be killed with water or mud and pump pressure applied. Should the pressure gauge on the casinghead reflect the applied pressure, the casing shall be condemned. After corrective measures have been taken, the casing shall be tested in the same manner. This method shall be used when the origin of the pressure cannot be determined otherwise.]~~

~~[(6) Christmas tree. All completed wells shall be equipped with Christmas tree fittings and wellhead connections with a rated working pressure equal to, or greater than, the surface shut-in pressure of the well. The tubing shall be equipped with a master valve, but two master valves shall be used on all wells with surface pressures in excess of 5,000 psi. All wellhead connections shall be assembled and tested prior to installation by a fluid pressure equal to the test pressure of the fitting employed.]~~

~~[(7) Storm choke and safety valve. A storm choke or similar safety device shall be installed in the tubing of all completed flowing wells to a minimum of 100 feet below the mud line. Such wells shall have the tubing-casing annulus sealed below the mud line. A safety valve shall be installed at the wellhead downstream of the wing valve. All oil, gas, and geothermal resource gathering lines shall have check valves at their connections to the wellhead.]~~

~~[(8) Pipeline shut-off valve. All gathering pipelines designed to transport oil, gas, condensate, or other oil or geothermal resource field fluids from a well or platform shall be equipped with automatically controlled shut-off valves at critical points in the pipeline system. Other safety equipment must be in full working order as a safeguard against spillage from pipeline ruptures.]~~

~~[(9) Training. Effective January 1, 1981, all tool pushers, drilling superintendents, and operators' representatives (when the operator is in control of the drilling) shall be required to furnish certification of satisfactory completion of a USGS-approved school] on well control equipment and techniques. The certification shall be renewed every two years by attending a USGS-approved refresher course. These training requirements apply to all drilling operations on lands which underlie fresh or marine waters in Texas.]~~

(d) Exceptions or alternate programs. The director may administratively grant an exception or approve an alternate casing/tubing program required by this section provided that the alternate casing/tubing program will achieve the intent of the rule as described in subsection (a)(1) of this section and the following requirements are met:

(1) The request for an exception or alternate casing/tubing program shall be accompanied by the fee required by §3.78(b)(5) of this title (relating to Fees and Financial Security Requirements).

(2) An administrative exception for tubing shall not exceed a period of 180 days. A request for an exception for tubing beyond 180 days shall require a Commission order.

§3.99. Cathodic Protection Wells.

(a) Definitions. The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

(1) - (2) (No change.)

(3) Protection depth--Depth or depths at which usable quality water must be protected or isolated, as determined by the Groundwater Advisory Unit of the Oil and Gas Division, which may include zones that contain brackish or saltwater if such zones are correlative and/or hydrologically connected to zones that contain usable-quality water.

(4) (No change.)

(b) - (h) (No change.)

§3.100. Seismic Holes and Core Holes.

(a) Definitions. The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

(1) - (3) (No change.)

(4) Protection depth--Depth or depths at which usable quality water must be protected or isolated, as determined by the Groundwater Advisory Unit of the Oil and Gas Division, which may include zones that contain brackish or saltwater if such zones are correlative and/or hydrologically connected to zones that contain usable-quality water.

(5) - (6) (No change.)

(b) - (g) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 30, 2013.

TRD-201300355
Cristina Martinez Self
Rules Attorney, Office of General Counsel
Railroad Commission of Texas
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 475-1295

♦ ♦ ♦

TITLE 22. EXAMINING BOARDS

PART 11. TEXAS BOARD OF NURSING

CHAPTER 211. GENERAL PROVISIONS

22 TAC §211.7

Introduction. The Texas Board of Nursing (Board) proposes an amendment to §211.7, relating to Executive Director. The amendment is proposed under the authority of the Occupations Code §§301.101, 301.151, 301.452, 301.453, 301.467, and 301.468 and is intended to: (i) reduce the volume of requests that must be heard by the Eligibility and Disciplinary Committee (Committee) of the Board; and (ii) reduce and/or eliminate the amount of time that individuals must wait to have their matters heard and decided by the Committee.

Background

The Committee has been designated by the Board to meet eight times a year, in the months where the full Board does not meet. The Committee is comprised of a three member panel of Board members. Pursuant to 22 TAC §211.6(b) and §213.23(a), the Committee has been authorized to make final decisions in all eligibility and disciplinary matters relating to the granting or denial of a license or permit, discipline, temporary suspension, or administrative and civil penalties. The Committee has historically permitted individuals to appear before it to request exceptions to stipulations in an existing eligibility or disciplinary Board order, to petition to have a limited license lifted and to be returned to direct patient care, and to request a limited license. Over time, these types of requests have grown in number and complexity. In 2009, approximately 25 of these types of requests were heard by the Committee. In 2010, approximately 31 of these requests were heard by the Committee. In 2011 and 2012, approximately 40 of these requests were heard by the Committee. In addition to these types of requests, the Committee also considers individuals petitioning for licensure eligibility and presenting motions for rehearing at its regular meetings. As a result, the Committee's designated meeting times are filled quickly, and individuals must sometimes wait several months before their requests can be heard and decided by the Committee. The proposed amendment is intended to reduce the amount of time individuals must wait to have their requests heard by the Committee and/or eliminate the need for certain individuals to appear before the Committee altogether.

Under the proposed amendment, the Executive Director is authorized to grant an individual's request for a limited license or an individual's request to have his/her limited license lifted and return to direct patient care. Further, under the proposed amendment, the Executive Director is authorized to review an individual's request for an exception to a stipulation in an existing eligibility or disciplinary Board order and to negotiate a resolution to the request, provided that the requested relief falls within the parameters of 22 TAC §213.33(b), (g), and (h) and is consistent with, and in the best interest of, the public health and safety. If the Executive Director is unable to resolve the request, or if the requested relief falls outside of the parameters of §213.33(b), (g), and (h), the individual will still be permitted to have his/her request heard and decided by the Committee. However, individuals whose requests are resolved by the Executive Director under the proposed amendment will not be required to appear before the Committee. Thus, the proposed amendment may save these individuals the time and potential expense of traveling to Austin, Texas to appear before the Committee and should enable individuals to have their requests resolved in a more timely and efficient manner.

The proposed amendment also requires the Executive Director to establish guidelines related to the review and approval of requests for exceptions to stipulations in existing eligibility and disciplinary orders of the Board, including how often such requests may be made. Further, the proposed amendment requires the Executive Director to report summaries of the decisions related to such requests to be reported to the Board at its regularly scheduled meetings. These proposed requirements are necessary to ensure appropriate Board oversight of its delegated processes and consistent and equal treatment of all similarly situated individuals requesting exceptions to stipulations in existing eligibility and disciplinary orders of the Board.

Section-by-Section Overview.

The proposed amendment to §211.7 adds new subsection (h) that authorizes the Executive Director to grant a request for a limited license or to negotiate an agreed order to return a limited licensee back to direct patient care. Further, the proposed amendment authorizes the Executive Director to negotiate an agreed resolution to a request for an exception to a stipulation contained in an existing order of the Board. The proposed amendment provides, however, that the Executive Director may not grant a request for an exception unless he/she is of the opinion that the requested relief falls within, and is consistent with, public safety and the parameters of 22 TAC §213.33(b), (g), and (h). The proposed amendment further provides that, in situations where the Executive Director cannot grant a request for an exception, the request may be scheduled without prejudice before the next practicable Committee meeting for review and determination. Further, the proposed amendment requires the Executive Director to establish guidelines for review and approval of requests for exceptions to existing Board orders, including how often such requests may be made. Finally, the proposed amendment requires the Executive Director to report summaries of decisions related to requests for exceptions to existing Board orders to the Board at its regularly scheduled meetings.

Fiscal Note. Katherine Thomas, Executive Director, has determined that for each year of the first five years the proposed amendment is in effect, there will be no additional fiscal implications for state or local government as a result of implementing the proposal.

Public Benefit/Cost Note. Ms. Thomas has also determined that for each year of the first five years the proposed amendment is in effect, the anticipated public benefit will be the adoption of requirements that provide for a more efficient process for individuals seeking a limited license, an exception to a stipulation in an existing eligibility or disciplinary order of the Board, or to return to direct patient care. Further, the proposed amendment may reduce the volume of the Committee's agendas, thereby minimizing the amount of time that individuals must wait to have their requests heard by the Committee. For those individuals whose requests may be resolved under the proposal, the proposed amendment will save such individuals the time and expense of traveling to Austin, Texas to appear before the Committee. Finally, the proposed amendment ensures that only those requests that are consistent with the Board's rules and are in the public's best interest may be resolved by the Executive Director. Requests that cannot be resolved by the Executive Director under the proposal will continue to be heard by the Committee. Such requirements ensure that the Board is able to continue to fulfill its mission of protecting the public health and safety through regulation.

Potential Costs to Comply with the Proposal

The Board does not anticipate any potential costs of compliance with the proposal. The proposed amendment provides a new process for resolving an individual's request for a limited license, for an exception to a stipulation in an eligibility or disciplinary order of the Board, or to return to direct patient care. However, the proposal does not impose or prescribe any new conditions or place any new requirements upon an individual submitting such a request. Further, the proposal does not require any individual to submit such a request. For individuals who choose to do so, the proposed amendment may reduce costs for individuals whose requests may be resolved by the Executive Director without the necessity of appearing before the Committee in Austin,

Texas. Further, for those individuals whose requests cannot be resolved by the Executive Director under the proposed amendment, the proposal continues to permit those individuals to appear before the Committee. However, the proposal does not require such individuals to do so, nor does the proposal alter the existing process that is currently in place that allows such individuals to appear before the Committee. Under the Board's existing practices, an individual may submit a request to appear before the Committee. The proposal does not alter such practice, nor does it impose any requirements on an individual wishing to avail him/herself of such practice. The proposal merely provides an alternative procedure for individuals whose requests are appropriate for resolution without the necessity of appearing before the Committee. As such, the Board does not anticipate any costs of compliance associated with the proposed amendment.

Economic Impact Statement and Regulatory Flexibility Analysis for Small and Micro Businesses. As required by the Government Code §2006.002(c) and (f), the Board has determined that it is not required to prepare a regulatory flexibility analysis because there are no anticipated costs of compliance with the proposal.

Takings Impact Assessment. The Board has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

Request for Public Comment. To be considered, written comments on the proposal or any request for a public hearing must be submitted no later than 5:00 p.m. on March 18, 2013, to James W. Johnston, General Counsel, Texas Board of Nursing, 333 Guadalupe, Suite 3-460, Austin, Texas 78701, or by e-mail to dusty.johnston@bon.texas.gov, or faxed to (512) 305-8101. If a hearing is held, written and oral comments presented at the hearing will be considered.

Statutory Authority. The amendment is proposed under the Occupations Code §§301.101, 301.151, 301.452, 301.453, 301.467, and 301.468.

Section 301.101(b) provides that, under the direction of the Board, the Executive Director shall perform the duties required by Chapter 301 or designated by the Board.

Section 301.151 provides that the Board may adopt and enforce rules consistent with Chapter 301and necessary to: (i) perform its duties and conduct proceedings before the Board; (ii) regulate the practice of professional nursing and vocational nursing; (iii) establish standards of professional conduct for license holders under Chapter 301; and (iv) determine whether an act constitutes the practice of professional nursing or vocational nursing.

Section 301.452(b) provides that a person is subject to denial of a license or to disciplinary action under Chapter 301, Subchapter J for: (i) a violation of Chapter 301, a rule or regulation not inconsistent with Chapter 301, or an order issued under Chapter 301; (ii) fraud or deceit in procuring or attempting to procure a license to practice professional nursing or vocational nursing; (iii) a conviction for, or placement on deferred adjudication community supervision or deferred disposition for, a felony or for a misdemeanor involving moral turpitude; (iv) conduct that results in the revocation of probation imposed because of conviction for a felony or for a misdemeanor involving moral turpitude; (v) use of a nursing license, diploma, or permit, or the transcript of such a document, that has been fraudulently purchased, issued, counterfeited, or materially altered; (vi) impersonating or acting as a proxy for another person in the licensing examination required under §301.253 or §301.255; (vii) directly or indirectly aiding or abetting an unlicensed person in connection with the unauthorized practice of nursing; (viii) revocation, suspension, or denial of, or any other action relating to, the person's license or privilege to practice nursing in another jurisdiction; (ix) intemperate use of alcohol or drugs that the Board determines endangers or could endanger a patient; (x) unprofessional or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public; (xi) adjudication of mental incompetency; (xii) lack of fitness to practice because of a mental or physical health condition that could result in injury to a patient or the public; or (xiii) failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the Board's opinion, exposes a patient or other person unnecessarily to risk of harm.

Section 301.452(c) provides that the Board may refuse to admit a person to a licensing examination for a ground described under §301.452(b).

Section 301.453(a) provides that if the Board determines that a person has committed an act listed in §301.452(b), the Board shall enter an order imposing one or more of the following: (i) denial of the person's application for a license, license renewal, or temporary permit; (ii) issuance of a written warning; (iii) administration of a public reprimand; (iv) limitation or restriction of the person's license, including limiting to or excluding from the person's practice one or more specified activities of nursing or stipulating periodic Board review; (v) suspension of the person's license; (vi) revocation of the person's license; or (vii) assessment of a fine.

Section 301.453(b) provides that, in addition to or instead of an action under §301.452(a), the Board, by order, may require the person to: (i) submit to care, counseling, or treatment by a health provider designated by the Board as a condition for the issuance or renewal of a license; (ii) participate in a program of education or counseling prescribed by the Board, including a program of remedial education; (iii) practice for a specified period under the direction of a registered nurse or vocational nurse designated by the Board; or (iv) perform public service the Board considers appropriate.

Section 301.453(c) provides that the Board may probate any penalty imposed on a nurse and may accept the voluntary surrender of a license. Further, the Board may not reinstate a surrendered license unless it determines that the person is competent to resume practice.

Section 301.453(d) states that, if the Board suspends, revokes, or accepts surrender of a license, the Board may impose conditions for reinstatement that the person must satisfy before the Board may issue an unrestricted license.

Section 301.467(a) states that, on application, the Board may reinstate a license to practice professional nursing or vocational nursing to a person whose license has been revoked, suspended, or surrendered.

Section 301.467(b) provides that an application to reinstate a revoked license: (i) may not be made before the first anniversary of the date of the revocation; and (ii) must be made in the manner and form the Board requires.

Section 301.467(c) provides that, if the Board denies an application for reinstatement, it may set a reasonable waiting period before the applicant may reapply for reinstatement.

Section 301.468(a) states that the Board may determine that an order denying a license application or suspending a license be probated. Further, a person subject to a probation order shall conform to each condition the Board sets as the terms of probation, including a condition: (i) limiting the practice of the person to, or excluding, one or more specified activities of professional nursing or vocational nursing; (ii) requiring the person to submit to supervision, care, counseling, or treatment by a practitioner designated by the Board; or (iii) requiring the person to submit to random drug or alcohol tests in the manner prescribed by the Board.

Section 301.468(b) states that at the time the probation is granted, the Board shall establish the term of the probationary period.

Section 301.468(c) states that at any time while the person remains subject to the probation order, the Board may hold a hearing and rescind the probation and enforce the Board's original action in denying or suspending the license. Further, the hearing shall be called by the presiding officer of the Board, who shall issue a notice to be served on the person or the person's counsel not later than the 20th day before the date scheduled for the hearing that: (i) sets the time and place for the hearing; and (ii) contains the charges or complaints against the probationer.

Section 301.468(d) provides that notice under §301.468(c) is sufficient if sent by registered or certified mail to the affected person at the person's most recent address as shown in the Board's records.

Section 301.468(e) states that a hearing under §301.468 is limited to a determination of whether the person violated the terms of the probation order under §301.468(a) and whether the Board should: (i) continue, rescind, or modify the terms of probation, including imposing an administrative penalty; or (ii) enter an order denying, suspending, or revoking the person's license.

Section 301.468(f) states that if one of the conditions of probation is the prohibition of using alcohol or a drug or participation in a peer assistance program, violation of that condition is established by: (i) a positive drug or alcohol test result; (ii) refusal to submit to a drug or alcohol test as required by the Board; or (iii) a letter of noncompliance from the peer assistance program.

Cross Reference to Statute. The following statutes are affected by this proposal: Occupations Code §§301.101, 301.151, 301.452, 301.453, 301.467, and 301.468

§211.7. Executive Director.

(a) - (g) (No change.)

(h) The Executive Director may grant a request for a limited license or negotiate an agreed order to return a limited licensee back to direct patient care. The Executive Director may negotiate an agreed resolution to a request for an exception to a stipulation contained in an existing order of the Board. The Executive Director shall not grant a request for exception under this subsection unless he/she is of the opinion that the requested relief falls within, and is consistent with, public safety and the parameters of §213.33(b), (g), and (h) of this title (relating to Factors Considered for Imposition of Penalties/Sanctions). Otherwise, a request for exception to an existing order of the Board may be scheduled without prejudice before the next practicable Eligibility and Disciplinary Committee meeting for review and determination. The Executive Director shall establish guidelines for review and approval of requests for exceptions to existing Board orders, including how often such requests may be made. The Executive Director shall report summaries of decisions related to requests for exceptions to existing Board orders to the Board at its regularly scheduled meetings.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 4, 2013.

TRD-201300433
Jena Abel
Assistant General Counsel
Texas Board of Nursing
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 305-6822

♦ ♦ ♦

CHAPTER 220. NURSE LICENSURE COMPACT

22 TAC §220.2

Introduction. The Texas Board of Nursing (Board) proposes amendments to §220.2, relating to Issuance of a License by a Compact Party State. The amendments are proposed under the Occupations Code Chapter 304, particularly §304.003 and §304.001, Articles 6(a)(4) and 8(c), and effectuate the adoption of uniform rules by party states.

Texas is a member of the Nurse Licensure Compact (Compact). The Compact is enacted and entered into with all other jurisdictions that legally join in the Compact. The Occupations Code Chapter 304 sets forth the provisions of the Compact. The Occupations Code Chapter 304, §304.001, Article 8(c) grants compact administrators the authority to develop uniform rules to facilitate and coordinate the implementation of the Compact. Model rules are routinely adopted and amended by the Nurse Licensure Compact Administrators (NLCA). Pursuant to §304.001, Articles 6(a)(4) and 8(c), party state members of the Compact, such as Texas, are statutorily required to adopt the uniform rules. The uniform rules are necessary to facilitate the mobility of nurses and cooperation among the party states.

The NLCA formally amended the Compact Model Rules and Regulations on November 13, 2012. The Board is proposing amendments to §220.2(f) and (g) to implement these changes. Currently, under §220.2(f), a nurse who is changing his/her primary state of residence from one party state to another may continue to practice under his/her former home state license and multistate privilege during the processing of his/her application in his/her new home state, for a period not to exceed 30 days. This time period, however, is often an inadequate amount of time for new party states to complete the application process. Often, documents from other jurisdictions must be received and reviewed and educational requirements must be verified. If a particular state has a large volume of applications, this process can take longer than 30 days. In an effort to avoid requiring a nurse to cease practicing while his/her application is being processed, the proposed amendment to §220.2(f) provides a nurse an additional 60 days in which he/she may practice while his/her application remains pending with his/her new home state. It is anticipated that this additional time period will allow the new home state an

appropriate amount of time to complete its application process and will permit nurses to continue working during the transition period into a new home state.

The proposed amendment to §220.2(g) is necessary for consistency with the proposed amendment to §220.2(f). The proposed amendment to §220.2(g) makes clear that the licensure application in the new home state and the 90-day period contemplated in proposed amended §220.2(f) may be abated and stayed pending the resolution of an investigation of a nurse by a former home state.

Section-by-Section Overview.

Proposed amended §220.2(f) states that a nurse changing his/her primary state of residence from one party state to another party state may continue to practice under the former home state license and multistate licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed 90 days.

Proposed amended §220.2(g) states that the licensure application in the new home state of a nurse under pending investigation by the former home state shall be held in abeyance and the 90-day period stated in proposed amended §220.2(f) shall also be stayed until resolution of the pending investigation.

Fiscal Note. Katherine Thomas, Executive Director, has determined that for each year of the first five years the proposed amendments are in effect, there will be no additional fiscal implications for state or local government as a result of implementing the proposal.

Public Benefit/Cost Note. Ms. Thomas has also determined that for each year of the first five years the proposed amendments are in effect, the anticipated public benefit will be the adoption of uniform rules that facilitate and coordinate implementation of the Compact. Further, the proposed amendments are designed to reduce and/or eliminate periods of time that a nurse may be required to stop practicing nursing in a new home state while waiting for his/her application to be processed. This promotes the mobility of nurses and provides additional flexibility to nurses who may be considering changing residences from one party state to another. Further, the proposed amendments benefit the people of the State of Texas by providing the option for more nurses to practice in this state while awaiting final approval of their applications, creating increased access to health care.

Potential Costs to Comply with the Proposal

The proposed amendments apply to individual applicants who seek to change their primary state of residence from another party state to another. However, the proposed amendments do not impose any requirements or conditions on such applicants. Rather, the proposed amendments (i) provide a grace period for individual applicants to continue practicing nursing while they are awaiting final approval of their licensure applications; and (ii) hold in abeyance an individual's application while awaiting resolution of a pending investigation in the nurse's former home state. Therefore, the Board does not anticipate there to be any costs associated with the proposal.

Economic Impact Statement and Regulatory Flexibility Analysis for Small and Micro Businesses. As required by the Government Code §2006.002(c) and (f), the Board has determined that the proposed amendments will not have an adverse economic effect on any individual, Board-regulated entity, or other entity required to comply with the proposal because there are no probable costs associated with the proposal.

Takings Impact Assessment. The Board has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

Request for Public Comment. To be considered, written comments on the proposal or any request for a public hearing must be submitted no later than 5:00 p.m. on March 18, 2013, to James W. Johnston, General Counsel, Texas Board of Nursing, 333 Guadalupe, Suite 3-460, Austin, Texas 78701, or by e-mail to dusty.johnston@bon.texas.gov, or faxed to (512) 305-8101. If a hearing is held, written and oral comments presented at the hearing will be considered.

Statutory Authority. The amendments are proposed under the Occupations Code Chapter 304, §304.003 and §304.001, Articles 6(a)(4) and 8(c).

Section 304.003 provides that the Board may adopt rules necessary to implement the Occupations Code Chapter 304.

Section 304.001, Article 6(a)(4) provides that party state nurse licensing boards have the authority to adopt uniform rules as provided under §304.001, Article 8(c) of the Compact.

Section 304.001, Article 8(c) provides that Compact administrators have the authority to develop uniform rules to facilitate and coordinate implementation of the Compact and the uniform rules shall be adopted by party states under §304.001, Article 6(a)(4) of the Compact.

Cross Reference to Statute. The following statutes are affected by this proposal: Occupations Code Chapter 304, §304.003 and §304.001, Articles 6(a)(4) and 8(c).

§220.2. Issuance of a License by a Compact Party State.

(a) - (e) (No change.)

(f) A nurse changing primary state of residence, from one party state to another party state, may continue to practice under the former home state license and multistate licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed ninety (90) [~~thirty~~] days.

(g) The licensure application in the new home state of a nurse under pending investigation by the former home state shall be held in abeyance and the ninety (90) [~~thirty~~] day period stated in subsection (f) of this section shall be stayed until resolution of the pending investigation.

(h) - (i) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 30, 2013.

TRD-201300364
Jena Abel
Assistant General Counsel
Texas Board of Nursing
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 305-6822

♦ ♦ ♦

TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 56. FAMILY PLANNING

The Executive Commissioner of the Texas Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes amendments to §§56.1 - 56.8, 56.10 - 56.14, and 56.16 - 56.19 and the repeal of §56.9, concerning family planning services.

BACKGROUND AND PURPOSE

Government Code, §2001.039, requires that each state agency review and consider for re-adoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). Sections 56.1 - 56.19 have been reviewed, and the department has determined that reasons for adopting §§56.1 - 56.8 and 56.10 - 56.19 continue to exist because rules on this subject are needed. However, the department also has determined that §56.9 is no longer needed and it is proposed for repeal.

The Family Planning Program provides statewide family planning services to low-income women and men who do not have other sources of payment for services. The target population is women and men of reproductive age who are at or below 250 percent of the Federal Poverty Level. Family planning services include preventive health, medical, counseling, and educational services. Additional services may include technical assistance and training for providers, information, and education activities for the public and providers.

SECTION-BY-SECTION SUMMARY

Amendments to §§56.1, 56.6, 56.11, 56.12, and 56.16 replace the terms "contractor(s)" with state "provider(s)."

Amendments to §§56.1, 56.2, and 56.4 replace references to the specific funding sources such as "Title V, X, and XX" with references to "family planning program" or "family planning services."

Amendments to §56.2 also remove statutory definitions for specific title funding sources, including Title V and Title XX, and remove the definition for "contractor."

Amendments to §56.3 provide increased clarity concerning the purpose of the family planning program.

Amendments to §56.5 allow providers flexibility to provide contraceptive services and ensure compliance with Title X regulations.

An amendment to §56.6 clarifies the section's sentence structure to emphasize that abortion is not considered a method of family planning, and no state funds appropriated to the department shall be used to pay the direct or indirect costs of abortion procedures provided by providers.

The amendment to §56.7 improves syntax and increases rule clarity.

An amendment to §56.8 adds the word "Department" to "providers" to increase rule accuracy.

Section 56.9 has been repealed because the time limit for providing family planning assistance to Medicaid clients in the current rule is not based on a Medicaid requirement.

Amendments to §56.10 clarify the intent and the wording of the section to emphasize that clients have the right to choose family planning methods and sources of services without coercion to accept services.

Amendments to §56.11 concerning confidentiality of personally identifying client information clarify that providers must adopt an internal policy and procedure concerning determination, documentation, and reporting of sexual and non-sexual abuse in accordance with the department's policy.

Amendments to §56.12 define eligibility for family planning services in terms of the department's requirements and re-emphasize that providers may not deny family planning services to eligible clients because of inability to pay.

Amendments to §56.13 increase clarity concerning consent by minors for family planning services.

Section 56.14 clarifies that adolescents should be offered services as soon as possible, rather than within a specific time period.

Amendments to §56.16 require that any media developed by a provider using Title X funds must acknowledge federal grant support.

Amendments to §56.17 delete requirements that the genetic services agency provider's records must comply with the department's records requirements and that the genetic services agency provider must arrange for full medical referral services. Additionally, amendments to §56.17 delete a provision concerning approval to conduct selected laboratory tests at regular clinical laboratories even for those laboratories that demonstrate the ability to perform the tests.

Amendments to §56.18 replace "amniocentesis" as a genetic service with "prenatal genetic diagnostic services" to meet Medicaid requirements.

An amendment to §56.19 requires that for the Title XIX Family Planning Genetics Program, genetic services for conditions that do not have serious psychosocial or medical implications for the client are not allowed.

FISCAL NOTE

David Auzenne, MPH, Manager, Preventive Care Branch, has determined that for each year of the first five years the amendments and repeal are in effect, there will be no fiscal implications to state or local governments as a result of administering the amendments and repeal as proposed. The proposal does not change current program structure and implementation. These amendments and repeal are intended to clarify, update, and streamline the rules and are not anticipated to be controversial or have significant fiscal impact to the department or local government.

MICRO-BUSINESSES AND SMALL BUSINESSES IMPACT ANALYSIS

Mr. Auzenne has determined that there will be no adverse economic impact on small businesses or micro-businesses required to comply with the amendments and repeal as proposed, because neither small businesses nor micro-businesses that are providers of family planning and family planning genetic services will be required to alter their business practices in order to comply with the amendments and repeal.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the amendments and repeal as proposed. There is no anticipated negative impact on local employment.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined as a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposed amendments and repeal do not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, do not constitute a taking under Government Code, §2007.043.

PUBLIC BENEFIT

Mr. Auzenne has also determined that for each year of the first five years the amendments and repeal are in effect, the public benefit anticipated as a result of administering the amendments and repeal will be continued access to quality reproductive health care to women and men to promote positive birth outcomes and healthy families.

PUBLIC COMMENT

Comments on the proposal may be submitted by mail to Claudia Himes-Crayton, Department of State Health Services, Mail Code 1923, P.O. Box 149347, Austin, Texas 78714-9347; by telephone at (512) 776-3861; or by email at claudia.himes-crayton@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register.*

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed amendments and repeal have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

25 TAC §§56.1 - 56.8, 56.10 - 56.14, 56.16 - 56.19

STATUTORY AUTHORITY

The amendments are authorized by Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Texas Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the sections implements Government Code, §2001.039.

The amendments affect Government Code, Chapter 531, and Health and Safety Code, Chapter 1001.

§56.1. Applicability of Family Planning Requirements.

The requirements in this chapter [~~each section~~] apply to department [~~Titles V, X, XIX (Medicaid), and XX~~] family planning programs unless otherwise specified within the section. Department Family Planning providers [~~planning contractors~~] are also required to observe all guidelines and operating procedures outlined in the most recent Family Planning Policy Manual, as required by their contracts. In addition to the requirements set out in Chapter 56, Title XIX (Medicaid) providers must comply with the terms and conditions of the Provider Agreement signed by all providers as a condition of participation in the Texas Medical Assistance Program.

§56.2. Definitions.

The following words and terms, when used in this chapter [~~subchapter~~], shall have the following meanings.

(1) - (3) (No change.)

[~~(4) Contractor--Any entity that contracts with the Department of State Health Services to provide Title V, X, and/or XX family planning services.~~]

(4) [~~(5)~~] Department--The Department of State Health Services.

(5) [~~(6)~~] Family planning services may include:

(A) health history and physical;

(B) counseling and education;

(C) laboratory testing;

(D) provision of a contraceptive method; and

(E) referrals for additional services as needed.

(6) [~~(7)~~] Intended pregnancy--Pregnancy a woman reports as desired at the time of conception.

(7) [~~(8)~~] Medicaid--Title XIX of the Social Security Act.

(8) [~~(9)~~] Provider--Any entity that receives Department or Title XIX [~~Titles V, X, XIX, or XX~~] funding to provide family planning services.

(9) [~~(10)~~] Region--Any of the public health service regions established by the Department of State Health Services.

[~~(11) Title V family planning program--Family planning services funded by grants under the Maternal and Child Health Act, 42 United States Code §701 *et seq.*~~]

(10) [~~(12)~~] Title X family planning program--Family planning services funded by grants under the Public Health Service Act, 42 United States Code §300 *et seq.*

(11) [~~(13)~~] Title XIX family planning program--Family planning services provided under Title XIX (Medicaid) of the Social Security Act, 42 United States Code §1396 *et seq.*

[~~(14) Title XX family planning program--Family planning services funded by grants under the Social Services Block Grant, 42 United States Code §1397 *et seq.*~~]

§56.3. Purposes.

The purposes of family planning services are:

(1) (No change.)

(2) to affect [~~positively~~] the outcome of future pregnancies positively;

(3) - (4) (No change.)

§56.4. Maximum Rates and Specific Codes.

For payment of purchased counseling, educational, medical, and sterilization department family planning services [~~funded by grants under Titles V, X, and XX,~~] maximum rates are established by the department according to specific diagnosis and procedure codes. The commission [~~Texas Health and Human Services Commission~~] sets fees, charges,

and rates for family planning services provided under Title XIX (Medicaid).

§56.5. Range of Methods.

A broad range of FDA-approved methods of contraception must be made available to the client, either directly or by referral to another provider of contraceptive services. All brands of the different contraceptive methods need not be made available; however, [~~but~~] each major contraceptive category must be made available.

§56.6. Abortion Statement.

Abortion is not considered a method of family planning, and no state funds appropriated to the department shall be used to pay the direct or indirect costs (including overhead, rent, phones, equipment, and utilities) of abortion procedures provided by department providers [~~contractors~~].

§56.7. Requirements for Reimbursement of Family Planning Services.

The commission and the department shall reimburse providers for services [~~provided~~] in compliance with program standards, policies and procedures, and contract requirements unless payment is prohibited by law.

§56.8. Records Retention.

Department providers [~~Providers~~] shall maintain for the time period specified by the department all records pertaining to client services, contracts, and payments. Title XIX (Medicaid) record retention requirements are found in 1 TAC [~~1 Texas Administrative Code,~~] §354.1004 (relating to Retention of Records). All records relating to services must be accessible for examination at any reasonable time to representatives of the commission and/or the department and as required by law.

§56.10. Freedom of Choice.

Clients have the right to choose [~~freely~~] family planning methods and sources of services freely. Clients shall not be coerced to accept services [~~subjected to coercion to accept services~~].

§56.11. Confidentiality.

Providers shall safeguard client family planning information. Clients must provide written authorization prior to the release of any personally identifying information except reports of child abuse required by Texas Family Code, Chapter 261, and as required or authorized by other law. The department may distribute appropriated funds only to providers [~~contractors~~] that show good faith efforts to comply with all child abuse reporting guidelines and requirements as interpreted by department policy.

(1) - (5) (No change.)

(6) The provider has an internal policy and procedure concerning determination, documentation, and reporting instances of sexual or non-sexual abuse in accordance with the department's Child Abuse Screening Documenting and Reporting Policy.

§56.12. Eligibility for Family Planning Services.

Family planning eligibility [~~Eligibility~~] shall be determined according to the requirements of the most recent department Family Planning Policy Manual. Department providers shall not deny family planning services to eligible clients because of their inability to pay for services. Title XIX (Medicaid) eligibility is determined by the guidelines set by the commission. Individuals who receive Medicaid are eligible for family planning medical, counseling, and educational services. [~~Contractors shall not deny family planning services to eligible clients because of their inability to pay for services.~~]

§56.13. Consent.

Providers may provide family planning services, to include [~~including~~] prescription drugs, without the consent of the minor's parent, managing conservator, or guardian only as authorized by Texas Family Code, Chapter 32, or by federal law or regulations. A provider may not require consent for family planning services from the spouse of a married client.

§56.14. Family Planning for Adolescents.

(a) Adolescents age 17 and younger shall be provided individualized family planning counseling and family planning medical services that meet their specific needs as soon as possible [~~within two weeks of request~~].

(b) The provider shall ensure that:

(1) - (4) (No change.)

(5) the adolescent is assured that all services are confidential and [~~that~~] any necessary follow-up contact will also protect the client's privacy.

§56.16. Title X Informational and Educational Committees.

Title X providers [~~contractors~~] that distribute informational and educational materials to clients and/or the community shall establish Informational and Educational (I&E) committees to review the materials. Providers [~~Contractors~~] should include all target populations in the development of educational materials.

(1) Each Title X provider [~~contractor~~] must maintain an I&E committee of no fewer than five but not more than nine members who are broadly representative of the population of the community for which the materials are intended in terms of demographic factors such as race, color, national origin, handicapped condition, sex, and age.

(2) Each I&E committee must review and approve all informational and educational materials developed or made available by the provider [~~contractor~~] prior to their distribution to assure that the materials are suitable for the population and community for which they are intended and to assure their consistency with the purposes of Title X.

(3) Each I&E committee must review the content of the materials to assure that the information is factually correct. The committee may delegate responsibility for the review of the factual, technical, and clinical accuracy to appropriate provider [~~contractor~~] staff. However, final approval of the informational and educational material rests with the I&E committee.

(4) (No change.)

(5) Materials provided by providers [~~contractors~~] must be reviewed and approved by each Title X provider's [~~contractor's~~] I&E committee, since community cultures and standards vary across the state.

(6) Each provider's [~~contractor's~~] I&E committee may meet as a group at a specific time and location, or the members may discuss the materials and make their determinations by telephone conference call.

(7) Each I&E committee shall review and approve informational and educational materials before distribution by the provider [~~contractor~~], and meetings shall be scheduled whenever new materials come under consideration, or on a regular basis according to an individual provider's [~~contractor's~~] policy. Providers' [~~Contractors'~~] I&E committees are not bound to conduct a minimum number of meetings per year.

(8) Any publication or other media developed by the provider using Title X funds must acknowledge federal grant support (grant number available from the department).

§56.17. Contract Requirements for the Title XIX (Medicaid) Family Planning Genetics Program.

(a) A genetic service agency provider may contract with the commission for Title XIX reimbursement for family planning genetic diagnostic and counseling services under the following conditions.

(1) The medical director of the genetic services agency provider is a clinical geneticist (MD or DO). The clinical geneticist must be an active candidate [~~board eligible~~] or board certified in clinical genetics by the American Board of Medical Genetics (ABMG) and licensed by the Texas Medical Board.

(2) (No change.)

[~~(3) The agency provider's records must contain multiple indexing for easy retrieval of information (by client name, by client number, and by syndrome, according to the International Classification of Diseases (current edition) with Clinical Modifications), and must comply with the department's records requirements.~~]

[~~(4) The agency provider must arrange for full medical referral services since genetic disorders often encompass several health problems. Independent consultant, laboratory, and radiology services must be billed through the genetic services agency provider under contract with the commission.~~]

(3) [~~(5)~~] Genetic counseling must be provided face-to-face by a clinical geneticist (MD or DO) or a genetic counselor under the direct supervision of a clinical geneticist.

(4) [~~(6)~~] Services provided by a specialized genetics agency provider must be under a written subcontractual agreement with the prime contractor. The commission has the right to approve all subcontractual agreements.

(5) [~~(7)~~] Any applicable state licensure or certification requirements must be met.

(b) Clinical laboratories that are part of the genetic services agency provider and external clinical laboratories used by genetic services agency providers must be directed by a clinical laboratory geneticist as defined by the ABMG. [~~In some cases, the department may approve selected laboratory tests to be conducted by regular clinical laboratories if these laboratories demonstrate the ability to perform these tests. All clinical laboratories must be certified by Title XVIII for services provided and further approved for participation in the Title XIX program.~~]

§56.18. Family Planning Genetics Services Provided.

Family planning genetics services must be prescribed by a physician (MD or DO) and have implications for reproductive decisions. Services may include the following, based on the client's needs:

(1) - (6) (No change.)

(7) prenatal genetic diagnostic services [~~amniocentesis~~]; and

(8) (No change.)

§56.19. Limitations of Family Planning Genetics Services.

For the Title XIX Family Planning Genetics Program, the following types of services are not allowed:

(1) genetic services for conditions that [~~usually~~] do not have serious psychosocial or medical implications for the client; and

(2) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 4, 2013.

TRD-201300434
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 776-6972

♦ ♦ ♦

25 TAC §56.9

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Department of State Health Services or in the Texas Register office, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

STATUTORY AUTHORITY

The repeal is authorized by Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Texas Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the sections implements Government Code, §2001.039.

The repeal affects Government Code, Chapter 531, and Health and Safety Code, Chapter 1001.

§56.9. Prompt Service.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 4, 2013.

TRD-201300435
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 776-6972

♦ ♦ ♦

CHAPTER 181. VITAL STATISTICS

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes amendments to §§181.1, 181.2, 181.6, 181.8 - 181.11, 181.13, 181.21 - 181.34, and 181.42 - 181.45 and new §§181.35, 181.50 - 181.54, and 181.60 - 181.65, concerning the administration and registration of vital statistics records.

BACKGROUND AND PURPOSE

Government Code, §2001.039, requires that each state agency review and consider for re-adoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act), according to the schedule listed therein. Sections 181.1, 181.2, 181.6, 181.8 - 181.11, 181.13, 181.21 - 181.34, and 181.42 - 181.45 have been reviewed, and the department has determined that the rules should continue

to exist, with the amendments, because rules on this subject are needed.

SECTION-BY-SECTION SUMMARY

The amendment to §181.1 updates definitions by adding a new definition for "Vital Statistics Unit;" deleting the definition for the "Bureau of Vital Statistics;" and revising various definitions to update legacy agency references.

The amendments to §§181.2, 181.9, 181.11, 181.13, 181.22, 181.23, 181.24, 181.27, 181.29 - 181.32, 181.34, and 181.42 - 181.45 clarify existing language and update legacy agency references from the "Bureau of Vital Statistics" to the "Vital Statistics Unit."

The amendments to §181.6 update recent operational changes, clarifying the responsibility of the State Registrar and Local Registrar's responsibility to file the disinterment permit as opposed to amending the certificate. This is in accordance with House Bill (HB) 2927, 81st Legislature, Regular Session, 2009, which amended Health and Safety Code, Chapter 711, relating to the regulation of cemeteries by state and local government.

Amendments to §181.8 update recent operational changes to enhance the confidentiality of adoption records by shredding paper birth records using a cross cut paper shredder and removing any birth records stored in electronic format from storage media in accordance with the National Institute of Standards and Technologies (NIST) "Guidelines for Media Sanitation" (Publication SP-800-88). The amendments also clarify the submittal of Acknowledgement of Paternity documents and update legacy agency references.

Amendments to §181.10 update legacy agency references and clarify the method of availability of birth record copies.

An amendment to §181.11 revises the legal reference in the Health and Safety Code from §191.005 and §192.006 to §191.0045.

The amendment to §181.21 clarifies the criteria for refusal of issuance of records.

The amendment to §181.25 updates legacy agency references and complies with legislative mandates in House Bill (HB) 3666, 81st Legislature, Regular Session, 2009, relating to the application for the issuance of a marriage license which amended Family Code, Subchapter C, §2.209, "Duplicate License."

The amendment to §181.26 updates recent operational changes and clarifies existing language regarding the filing of birth certificates for infants born outside of a licensed institution.

The amendments to §181.28 update recent operational changes, clarify existing language, and address recommendations of Rider 72, 82nd Legislature, 2011, the 2006 Internal Audit, and the 2009 State Audit to issue birth certificates only to qualified applicants.

The amendments to §181.33 update legacy agency references and update obsolete language relative to the completion of a certificate of death.

New §181.35 complies with legislative mandates in HB 3666, 81st Legislature, Regular Session, 2009, which amended Family Code, Subchapter B, §2.102, "Parental Consent of Underage Applicants to Marriage," relating to the application for the issuance of a marriage license.

The amendments to §§181.42 - 181.45 update policies and procedures concerning the Central Adoption Registry.

New §§181.50 - 181.54 concern birth registration, certification requirements and procedures, continuing education requirements and application for Birth Registrar certification and recertification.

New §§181.60 - 181.65 concern delayed birth certification; requirements and acceptability of documentation; verification by the State Registrar; and dismissal after non-completion of application within one year.

FISCAL NOTE

Geraldine Harris, Unit Director of the Vital Statistics Unit, has determined that for each year of the first five years that the sections are in effect, there will be no fiscal implications to state or local governments as a result of enforcing and administering the sections as proposed.

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS

Ms. Harris has also determined that there will be no adverse economic costs to small businesses or micro-businesses required to comply with the sections as proposed. This was determined by interpretation of the rules that small businesses and micro-businesses will not be required to alter their business practices in order to comply with the sections.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated costs to persons who are required to comply with the sections as proposed. There is no anticipated negative impact on local employment.

PUBLIC BENEFIT

Additionally, Ms. Harris has also determined that for each year of the first five years the sections are in effect, the public will benefit from their adoption. These rules impact the people of Texas whose vital records are stored and safeguarded by the Texas Vital Statistics Unit.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKING IMPACT ASSESSMENT

The department has determined that the proposed rules do not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, do not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposal may be submitted to Albert Rivera, Health Information and Vital Statistics, Vital Statistics Unit, Department of State Health Services, Mail Code 1966, P.O. Box

149347, Austin, Texas 78714-9347, telephone (512) 776-7696 or albert.rivera@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register.*

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

SUBCHAPTER A. MISCELLANEOUS PROVISIONS

25 TAC §§181.1, 181.2, 181.6, 181.8 - 181.11, 181.13

STATUTORY AUTHORITY

The amendments are authorized by Health and Safety Code, §191.002, which authorizes rules necessary for the effective administration of Vital Statistics Records; Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the sections implements Government Code, §2001.039.

The amendments affect Health and Safety Code, Chapters 191 and 1001; and Government Code, Chapter 531.

§181.1. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) - (2) (No change.)

[~~(3) Bureau of Vital Statistics (Bureau)--The office within the Texas Department of Health charged with the implementation of the Texas Vital Statistics Act.~~]

(3) [~~(4)~~] Certified--A certified statement, form, or letter, of the facts stated on the form or document as filed in the Vital Statistics Unit [~~Bureau of Vital Statistics~~], certified by the State Registrar [~~state registrar~~] or duly appointed designee, over the respective signature and may bear the seal of the Vital Statistics Unit [~~Bureau of Vital Statistics~~].

(4) [~~(5)~~] Certified copy--An abstract or photocopy of the original record issued as filed with the Vital Statistics Unit [~~Bureau of Vital Statistics~~], and issued on a designated form or security paper which shall bear the "state seal," [~~,~~] the Texas Department of State Health Services, Vital Statistics Unit [~~Department of Health-Bureau of Vital Statistics~~] or the seal of their office, and the facsimile signature of the State Registrar or the local registration official.

(5) [~~(6)~~] Dead body--A lifeless human body or such parts of the human body or the bones thereof from the state of which it may be reasonably concluded that death occurred.

(6) [~~(7)~~] Disinterment--To exhume, unbury, or take out of the grave.

(7) [~~(8)~~] Death records--Records governing deaths and fetal deaths filed pursuant to the Texas Vital Statistics Act.

(8) [~~(9)~~] Department--The Texas Department of State Health Services, formerly known as the Texas Department of Health.

(9) [~~(10)~~] Embalming--The act of disinfecting or preserving a human dead body, entire or in part, by the use of chemical substances, fluids, or gases in the body; or by the introduction of the same into the body by vascular or hypodermic injection; or by direct application into the organs or cavities; or by any other method intended to disinfect or preserve a dead body or restore body tissues and structures.

(10) [~~(11)~~] Fetal death (stillbirth)--Death prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

(11) [~~(12)~~] Genealogist--An individual who traces the descent of persons or families. He or she may be an individual family member or a person hired by the family to trace a family tree or do family research.

(12) [~~(13)~~] Identification of applicant--Each applicant must present a current form of government issued photo identification along with his or her application. If the applicant is unable to present a current form of photo identification, two valid supporting forms of identification may be presented, one of which bears the applicant's signature.

(13) [~~(14)~~] Immediate family member--The registrant, his or her guardian, or the children, spouses, parents, siblings, or grandparents of the registrant.

(14) [~~(15)~~] Indexes--An index to or listing of birth records, death records, applications for marriage licenses, and reports of divorce or annulment of marriage.

(A) Consolidated indexes--These indexes are vital records consisting of more than one event year. Consolidated indexes may be prepared for any vital event at the discretion of the State Registrar in the form prescribed.

(B) General birth and death indexes--These indexes are maintained or established by the Vital Statistics Unit [~~bureau of vital statistics~~] or a local registration official which shall be prepared by event year, in alphabetical order by surname of the registrant, followed by any given names or initials, the date of the event, the county of occurrence, the state or local file number, the name of the father, the maiden name of the mother, and sex of the registrant.

(C) Summary birth and death index--These indexes are maintained or established by the Vital Statistics Unit [~~Bureau of Vital Statistics~~] or a local registration official which shall be prepared by event year, in alphabetical order by surname of the registrant, followed by any given names or initials, the date of the event, the county of occurrence, and sex of the registrant.

(15) [~~(16)~~] Interment--Burial or the act of placing in a grave.

(16) [~~(17)~~] Legal representative (personal representative or agent)--An attorney in fact, a funeral director, or any other person designated by affidavit, contract, or court order acting on behalf and for the benefit of the registrant or his or her immediate family. In order to determine the need for protection for personal property rights when the legal representative is acting on behalf and for the benefit of the registrant or the registrant's immediate family or other entity having a direct and tangible interest in the record, the State Registrar [~~state registrar~~], Local Registrar [~~local registrar~~], or county clerk shall require a designation document or an attested statement to that effect.

(17) [~~(18)~~] Live birth--The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the

umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live born.

(18) [~~(19)~~] Local registration official--A county clerk or person authorized by the Vital Statistics Act to maintain a duplicate system of records for each birth, death, or fetal death that occurs in the person's jurisdiction.

(19) [~~(20)~~] Non-institutional birth [~~Birth~~]--A birth occurring outside a hospital or birthing center licensed by the Texas Department of State Health Services.

(20) [~~(21)~~] Person in charge of interment--Any person who places or causes to be placed a fetus, dead body or the ashes, after cremation, in a grave, vault, urn, or other receptacle, or otherwise disposes thereof.

(21) [~~(22)~~] Properly qualified applicant (qualified applicant)--The registrant, or immediate family member either by blood, marriage or adoption, his or her guardian, or his or her legal agent or representative. Local, state and federal law enforcement or governmental agencies and other persons may be designated as properly qualified applicants by demonstrating a direct and tangible interest in the record when the information in the record is necessary to implement a statutory provision or to protect a personal legal property right. A properly qualified applicant may also be a person who has submitted an application for a request to release personal information and has been approved as outlined in §181.11 of this title (relating to Requests for Personal Data).

(22) [~~(23)~~] Registrant--The individual named on the certificate of birth, death, or fetal death; application for marriage license; or report of divorce or annulment of marriage.

(23) [~~(24)~~] Registrar--The State Registrar or a Local Registrar [~~local registrar~~] as recognized by the Texas Department of State Health Services, [~~Bureau of~~] Vital Statistics Unit.

(24) [~~(25)~~] Research copy--A plain paper noncertified reproduction of the complete original document or a portion of the original document.

(25) [~~(26)~~] Search--The act of examining the files and/or indexes maintained by the Vital Statistics Unit [~~Bureau of Vital Statistics~~] for a specific record or information.

(26) [~~(27)~~] Signature--The name of a person written with his or her own hand; or by an electronic process approved by the State Registrar.

(27) [~~(28)~~] State Registrar--The Unit Director [~~Chief, Bureau~~] of the Vital Statistics Unit, Texas Department of State Health Services.

(28) [~~(29)~~] Supplemental Birth Certificate--A new birth certificate prepared and filed by the Vital Statistics Unit [~~Bureau~~], which is based upon a paternity determination, or adoption. This new birth certificate replaces the original certificate of birth.

(29) [~~(30)~~] Birth Verification--A noncertified statement only of the registrant's name, date of birth, and place of birth as it appears on the birth index filed with the [~~Bureau of~~] Vital Statistics Unit.

(30) [~~(31)~~] Death Verification--A noncertified statement only of the registrant's name, date of death, and place of death as it appears on the death index filed with the [~~Bureau of~~] Vital Statistics Unit.

(31) [~~(32)~~] Fetal Death Verification--A noncertified statement only of the registrant's name, date of delivery, and place of delivery as it appears on the fetal death index filed with the [~~Bureau of~~] Vital Statistics Unit.

(32) [~~(33)~~] Marriage Verification--A noncertified statement only of the registrant's name, date of marriage, and place of marriage as it appears on the application for marriage license index filed with the [~~Bureau of~~] Vital Statistics Unit.

(33) [~~(34)~~] Report of Divorce or Annulment of Marriage Verification--A noncertified statement only of the registrant's name, date of divorce, and place of divorce as it appears on the report of divorce or annulment of marriage index as it appears on the birth index filed with the [~~Bureau of~~] Vital Statistics Unit.

(34) [~~(35)~~] Vital statistics--The registration, preparation, transcription, collection, compilation, distribution and preservation of data pertaining to births, adoptions, paternity determinations, deaths, fetal deaths, suits affecting parent child relationship, court of continuing jurisdiction, marital status, and such other data as deemed necessary by the department.

(35) [~~(36)~~] Vital Statistics Act--The Health and Safety Code, Title 3.

(36) Vital Statistics Unit--The office, formally known as the Bureau of Vital Statistics, within the Texas Department of State Health Services, formerly known as the Texas Department of Health, charged with the implementation of the Texas Vital Statistics Act.

§181.2. Assuming Custody of Body.

(a) The funeral director, or person acting as such, who assumes custody of a dead body or fetus shall obtain an electronically filed report of death through a [~~Bureau of~~] Vital Statistics Unit system or complete a report of death before transporting the body. The report of death shall within 24 hours be mailed or otherwise transmitted to the Local Registrar [~~local registrar~~] of the district in which the death occurred or in which the body was found. A copy of the completed or electronically filed report of death as prescribed by the [~~Bureau of~~] Vital Statistics Unit shall serve as authority to transport or bury the body or fetus within this state.

(b) If a dead body or fetus is to be removed from this state, transported by common carrier within this state, or cremated, the funeral director, or person acting as such, shall obtain a burial-transit permit from the Local Registrar [~~local registrar~~] where the death certificate is or will be filed, or from the State Registrar [~~state registrar~~] electronically through a [~~Bureau of~~] Vital Statistics Unit electronic death registration system. The registrar shall not issue a burial-transit permit until a certificate of death, completed in so far as possible, has been presented (See §181.6 of this title (relating to Disinterment)).

(c) (No change.)

§181.6. Disinterment.

(a) Except as is authorized for a justice of the peace acting as coroner or medical examiner under the Code of Criminal Procedure, Chapter 49, remains may not be removed from a cemetery except on written order of the State Registrar [~~state registrar~~] or the State Registrar's [~~state registrar's~~] designee.

(b) The licensed funeral director or professional archeologist to whom the disinterment permit is issued shall be responsible for the proper conduct of the disinterment and removal.

(c) The State Registrar [~~state registrar~~] shall issue a disinterment permit so as to provide a copy for the State Registrar [~~state registrar~~], a copy retained by the funeral director or professional archeologist to whom issued, a copy filed with the sexton or person in charge

of the cemetery in which the disinterment is to be made, and a copy for the Local Registrar [~~local registrar~~] of the district in which the death occurred. The State Registrar and the Local Registrar shall file the disinterment permit as an amendment to the death certificate and consider it part of the death certificate. The State Registrar and the Local Registrar shall include a copy of the disinterment permit with any future certified copies of the death certificate that are issued. [~~The state registrar and the local registrar shall amend the certificate of death filed in their respective offices.~~]

(d) - (g) (No change.)

(h) The disinterment permit issued by the State Registrar [~~state registrar~~] shall serve as the authority to disinter, transport by means other than a common carrier, and re-inter a body within this state. (See §181.2 of this title (relating to Assuming Custody of Body).

(i) - (l) (No change.)

§181.8. Supplemental Birth Certificates.

(a) (No change.)

(b) Wherever possible, the local registration official shall remove from his or her files the original birth record and: [~~forward it to the bureau.~~]

(1) Shred any paper birth records using a cross cut paper shredder; and

(2) Remove any birth records stored in electronic format from storage media using validated overwriting technologies and methods/tools that clear data using 1-3 overwrites in accordance with National Institute of Standards and Technologies (NIST) "Guidelines for Media Sanitation" (Publication SP-800-88).

(c) Where it is not possible to remove the original birth record, the local registration official shall cancel such record in such manner as to preclude the disclosure of any information contained therein. In its place he or she shall substitute the supplemental certificate of birth.

(d) [~~(c)~~] A certificate of adoption for a child born outside the State of Texas shall, when received by the Vital Statistics Unit [~~bureau~~] be forwarded to the proper registration official of the state or territory in which such birth occurred. (For foreign adoptions, see §181.29 of this title (relating to Foreign Adoptions)).

(e) [~~(d)~~] Where application is made for the filing of a supplemental certificate based on paternity, the applicant shall submit to the Vital Statistics Unit [~~bureau~~] an Application for New Birth Certificate Based on Parentage (VS-166) signed by both parents in the presence of a Notary Public, and:

(1) a certified copy of the certificate of marriage indicating the subsequent marriage of the parents; or

(2) a copy of the [~~an~~] Acknowledgment of Paternity (VS-159.1) that has been properly filed by the Vital Statistics Unit [~~if an Acknowledgment of Paternity is not already in the bureau files~~]; or

(3) a certified copy of the court decree establishing paternity [~~if the information concerning the court decree is not already in the bureau files~~]. If a court decree is presented [~~in the bureau files~~], the Application for New Birth Certificate Based on Parentage only has to be signed by one of the parents in the presence of a Notary Public.

(4) a certified copy of the court decree establishing a gestational agreement. The Application for New Birth Certificate Based on Parentage must be signed by at least one parent in the presence of a Notary Public.

(f) [~~(e)~~] Voluntary Paternity must have a written consent of both parents.

§181.9. Access to Paternity Files.

(a) (No change.)

(b) The Vital Statistics Unit [~~bureau~~] shall notify the Office of the Attorney General, the Title IV-D agency for the State of Texas, in a manner agreed by both agencies of any supplemental birth records based upon acknowledgement of paternity.

§181.10. Availability of Birth Records to Ensure Confidentiality of Adoption Placement.

(a) (No change.)

(b) Availability of birth records generally.

(1) Copies of birth records are available for request by [~~to~~] the public for searching or inspection, in accordance with Government Code, §552.115, on or after the 75th anniversary of the date of birth as shown on the record filed with the Vital Statistics Unit [~~bureau~~] or the local registration official. Original birth records shall not be made available to the public in the interest of preservation of the records.

(2) (No change.)

§181.11. Requests for Personal Data.

(a) - (b) (No change.)

(c) Procedures.

(1) - (5) (No change.)

(6) The Vital Statistics Unit [~~Bureau~~] shall charge the statutory fee for each vital record research copy as provided in the Health and Safety Code, §191.0045 [~~§§191.005 and 192.006~~].

(7) (No change.)

§181.13. Birth Certificate Form and Content.

(a) - (c) (No change.)

(d) The Vital Statistics Unit [~~bureau~~] may discontinue any institution or individual's participation in electronic birth registration for failure to comply with the User Agreement.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300421
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 776-6972

♦ ♦ ♦

SUBCHAPTER B. VITAL RECORDS

25 TAC §§181.21 - 181.35

STATUTORY AUTHORITY

The amendments and new rule are authorized by Health and Safety Code, §191.002, which authorizes rules necessary for the effective administration of Vital Statistics Records; Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and

policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the sections implements Government Code, §2001.039.

The amendments and new rule affect Health and Safety Code, Chapters 191 and 1001; and Government Code, Chapter 531.

§181.21. Refusal to [To] Issue Certified Copies of Records of Birth, Death, or Fetal Death.

(a) Purpose. The purpose of this section is to describe:

(1) (No change.)

(2) the hearing procedures the department will use when the applicant wants to appeal the State Registrar's [state registrar's] proposed refusal.

(b) Criteria for refusal. The criteria for refusal to issue a certified copy of a record is based on information the State Registrar [state registrar that] receives that contradicts the information shown in the record, such as:

(1) - (3) (No change.)

(c) (No change.)

§181.22. Fees Charged for Vital Records Services.

(a) - (e) (No change.)

(f) The fee to search for any record or information on file within the Vital Statistics Unit [Bureau] shall be $10.00, regardless of whether a certified copy is issued or not.

(g) - (i) (No change.)

(j) The fee for filing an amendment to an existing certificate of birth or death on file with the Vital Statistics Unit [bureau] shall be $15.00. An amendment to a certificate includes adding information to a record to make it complete and changing information on a record to make it correct. An additional fee is required to issue a certified copy of the amended record.

(k) - (s) (No change.)

§181.23. Indexes for Vital Records.

(a) The State Registrar [state registrar] shall establish and maintain an index of all vital records filed within the [Bureau of] Vital Statistics Unit. Local registration officials shall establish and maintain an index of all vital records filed within their local registration area.

(b) Birth indexes.

(1) General birth indexes maintained or established by the Vital Statistics Unit [bureau of vital statistics] or a local registration official shall be prepared by event year, in alphabetical order by surname of the registrant, followed by any given names or initials, the date of the event, the county of occurrence, the state or local file number, the name of the father, the maiden name of the mother, and sex of the registrant.

(2) A general birth index is public information and available to the public to the extent the index relates to a birth record that is public on or after the 75th anniversary of the date of birth as shown on the record unless the fact of an adoption or paternity determination can be revealed or broken or if the index contains specific identifying information relating to the parents of the child who is the subject of an adoption placement. The Vital Statistics Unit [bureau of vital statistics] and local registration officials shall expunge or delete any state or local file numbers included in any general birth index made available to the public because such file numbers may be used to discover information concerning specific adoptions, paternity determinations, or the identity of the parents of children who are the subjects of adoption placements.

(3) A summary birth index maintained or established by the Vital Statistics Unit [bureau of vital statistics] or a local registration official shall be prepared by event year, in alphabetical order by surname of the registrant, followed by any given names or initials, the date of the event, the county of occurrence, and sex of the registrant. A summary birth index or any listings of birth records are not available to the public for searching or inspection if the fact of adoption or paternity determination can be revealed from specific identifying information.

(c) Death indexes.

(1) A general death index maintained or established by the Vital Statistics Unit [bureau of vital statistics] or a local registration official shall be prepared by event year, in alphabetical order by surname of the registrant, followed by any given names or initials; the date of the event; the county of occurrence; the registrant's social security number, sex, and marital status; the name of the registrant's spouse, if applicable; and the state or local file number.

(2) (No change.)

(3) A summary death index maintained or established by the Vital Statistics Unit [bureau of vital statistics] or a local registration official shall be prepared by event year, in alphabetical order by surname of the registrant, followed by any given names or initials, the date of the event, the county of occurrence, and sex of the registrant.

(d) - (e) (No change.)

§181.24. Abuse, Misused, or Flagged Records.

(a) Abused birth record.

(1) (No change.)

(2) Local Registrars [registrars] shall notify the Vital Statistics Unit [Bureau] of any abused record. Requests for additional certifications shall be made to the Vital Statistics Unit [bureau].

(3) When the State Registrar [state registrar] receives a request for an abused birth record, he/she shall refuse to issue any additional certifications until the registrant, minor registrant's parent who is not excluded by law, or registrant's guardian has satisfactorily explained, the reason for the additional request(s).

(b) Misused record.

(1) (No change.)

(2) Upon notification or determination that a record has been misused, the State Registrar [state registrar] shall attach a flag or notice to the record.

(c) Flagged record.

(1) (No change.)

(2) The Vital Statistics Unit [bureau] will flag the record of any missing child who is under the age of eleven, when notified by a law enforcement agency or the Missing Persons Clearinghouse.

(3) When a record has a notation, or addendum, the State [state] and Local Registrar [local registrar] shall refuse to issue such a record until the conditions as stated on the notation, or addendum have been satisfied and the registrant or the requesting party has been notified.

(d) A hearing may be requested as provided in §181.21 [§181.21(d)] of this title (relating to Refusal to [To] Issue Certified

Copies of Records of Birth, Death, or Fetal Death) to determine if flagged, abused, misused or records with an addendum or notation should be issued.

§181.25. Application for Marriage License and Affidavit of Correction to Marriage License.

(a) The Vital Statistics Unit [~~bureau~~] shall furnish application forms for a marriage license to each county clerk in the format as prescribed by the State Registrar.

(b) (No change.)

(c) When reproduced locally by the county clerk, the form shall be identical in content, format, and size as prescribed by the Vital Statistics Unit [~~bureau~~].

(d) Although the Vital Statistics Unit is the custodian of marriage applications in the State of Texas, the county of record is the custodian of all marriage licenses it registers. Therefore, any amendment to the marriage license will be reflected at the county, and not at the state level.

(e) To amend the marriage license, both parties are responsible for executing a notarized affidavit stating the error.

(f) The affidavit to amend the marriage license must contain:

(1) the full names of applicants, including the maiden surname of the female applicant;

(2) the date on which the marriage occurred;

(3) a statement identifying the error to be corrected; and

(4) the corrected statement.

(g) Upon receipt of the notarized affidavit, the county clerk shall file it as an amendment to the marriage license.

(h) The affidavit is considered part of the marriage license.

(i) The county clerk shall include a copy of the affidavit with any future certified copy of the marriage license issued by the clerk.

§181.26. Filing of Birth Certificates for Infants Born Outside of a Licensed Institution.

(a) (No change.)

(b) A registered, certified, or documented health care provider's signature on the birth certificate, or participation in electronic birth registration shall serve as prima facie evidence of the essential elements of proof required in subsection (c) of this section. The Local Registrar [~~local registrar~~] may accept certificates by mail when the signature of the registered, certified, or documented health care provider is on file with that registrar's office.

(c) The essential elements to register a non-institutional birth are:

(1) evidence [~~proof~~] of pregnancy;

(2) evidence [~~proof~~] that there was an infant born alive;

(3) evidence [~~proof~~] that the birth occurred in the registration district; and

(4) evidence [~~proof~~] that the infant's birth occurred on the date stated.

(d) Evidence of pregnancy, such as but not limited to:

(1) prenatal record;

(2) a statement from a physician or other health care provider qualified to determine pregnancy;

(3) a home visit by a public health nurse or other health care provider; or

(4) other evidence acceptable to the Local Registrar.

(e) Evidence that there was an infant born alive, such as, but not limited to:

(1) a statement from the physician or other health care provider who saw or examined the infant;

(2) an observation of the infant during a home visit by a public health nurse; or

(3) other evidence acceptable to the Local Registrar.

(f) Evidence that the birth occurred in the registration district, such as, but not limited to the following.

(1) If the live birth occurred in the mother's residence:

(A) a rent receipt that includes the mother's name and address;

(B) any type of utility, telephone, or other bill that includes the mother's name and address;

(C) a credit or debit card receipt that includes the date and location of the transaction;

(D) a driver's license, or a State-issued identification card, which includes the mother's current residence on the face of the license/card; or

(E) other evidence acceptable to the Local Registrar.

(2) If the live birth occurred outside of the mother's place of residence, and the mother is a resident of this State, such evidence shall consist of:

(A) an affidavit from the tenant of the premises where the live birth occurred, that the mother was present on those premises at the time of the live birth;

(B) evidence of the affiant's residence similar to that required in paragraph (1) of this subsection;

(C) evidence of the mother's residence in the State similar to that required in paragraph (1) of this subsection; or

(D) other evidence acceptable to the Local Registrar.

(3) If the mother is not a resident of this State, such evidence must consist of clear and convincing evidence acceptable to the Local Registrar.

(g) Evidence that infant's birth occurred on the date stated, includes but is not limited to:

(1) prenatal record;

(2) a statement from a physician or other health care provider qualified to determine the date of birth; or

(3) other evidence acceptable to the Local Registrar.

(h) [~~(d)~~] A birth as described in subsection (c) of this section shall only be filed upon personal presentation of the following evidence by the individual responsible for the preparation and registering of the certificate. An identifying document, with photograph, shall be presented in the following order of preference:

(1) a passport or certificate of naturalization;

(2) a military service or military dependent identification card;

(3) a United States government identification card, or national identification card issued by another country;

(4) a current driver's license or other state identification card;

(5) an alien registration receipt card; or

(6) an employee or student identification card, with photograph.

[(e) At the discretion of the local registrar, the requirements contained in this section may be supplemented with any additional requirements which may be needed to verify the circumstances of the birth. Such additional requirements may include, but are not limited to, one or more of the following:]

[(1) an unannounced visit to the mother's residence or the place of the alleged birth by a public health nurse, other health professional, registrar staff, or other person including city, county, state, or federal law enforcement officer, prior to registering the alleged birth. This paragraph does not permit nor give authority to enter these premises unless permission is obtained from the occupant at the time of the visit;]

[(2) multiple forms of identifying documents, with or without photographs, when the documents described in this section are unavailable;]

[(3) personal appearance of both parents, either together or separately; or]

[(4) personal appearance of the infant whose birth certificate the parents are attempting to file.]

[(f) If the required or supplemental evidence described in this section is not available and the registrar is otherwise unable to verify the circumstances of the birth, the birth may only be filed upon order of a court of competent jurisdiction.]

(i) [(g)] A certificate of birth concerning a child who is between one and four years of age may only be filed by the State Registrar [state registrar]. The State Registrar [state registrar] shall require the same proof and documentation as previously mentioned in this section and, in addition, an affidavit of the parents and the attendant, if any, as to why the certificate was not timely filed. If the proof and documentation are not available, the certificate may only be filed as prescribed by the Health and Safety Code, §192.027.

(j) [(h)] Each Local Registrar [local registrar] shall notify the State Registrar's [state registrar's] office of any suspicious documents or records submitted or filed with his/her office.

(k) [(i)] Blank birth certificate forms shall only be issued to licensed institutions, certified nurse midwives, documented midwives, and individuals by the Local Registrar [local registrar] or the State Registrar [state registrar] in reasonable amounts. No blank birth certificate forms shall be distributed by mail to any one other than a registered, certified, or documented health care provider.

[(j) Each local registrar shall maintain a record of the number of blank birth certificate forms and their control number issued to each individual. The local registrar shall submit a copy of this record to the state registrar on a monthly basis.]

§181.27. Memorandum of Understanding with the Texas Funeral Service Commission.

(a) The purpose of this section is to implement Texas Occupations Code, Chapter 651, and Health and Safety Code, Chapters 193 and 195. In an effort to better protect the public health, safety and welfare, it is the legislative intent of the laws for the Texas Department of State Health Services (department) and the Texas Funeral Service Commission (TFSC) to adopt by rule a memorandum of understanding to facilitate cooperation between the agencies by establishing joint procedures and describing the actual duties of each agency for the referral, investigation, and resolution of complaints affecting the administration and enforcement of state laws relating to vital statistics and the licensing of funeral directors and funeral establishments.

(b) (No change.)

§181.28. Instructions and Requirements for Issuance of Certified Copies of Vital Records by the State Registrar, Local Registrar, or County Clerk.

(a) Birth certificates.

(1) The State Registrar, Local Registrar [state registrar, local registrar], or county clerk shall issue only two types of certified copies:

(A) (No change.)

(B) an abstract of birth facts, taken from the original record. Probate records and delayed records may not be abstracted. An abstract shall be issued in one of three [four] styles:

(i) (No change.)

[(ii) a wallet-sized certified abstract;]

(ii) [(iii)] an electronic or computer generated [a typewritten] certified abstract prepared in accordance with Health and Safety Code, §192.005 or §192.011, or when the condition of the original record does not permit full reproduction; or

(iii) [(iv)] an heirloom style certified abstract which may only be issued by the State Registrar.

(2) Each certified copy of a record, or abstract of birth facts, shall be issued over the signature or facsimile thereof of the officer to whom the record is entrusted, and shall bear the seal of their office, and a statement of certification:

(A) (No change.)

(B) as authorized to be issued from the State Registrar's [state registrar's] file.

(3) (No change.)

(b) Death certificates.

(1) The State Registrar, Local Registrar [state registrar, local registrar], or county clerk shall issue only two types of certified copies:

(A) - (B) (No change.)

(2) (No change.)

(c) Security features. No certified copy or abstract shall be issued unless the issuing office provides security features in the paper used for issuance. Each sheet or document shall be made on paper which contains as a minimum the following security features in accordance with the security standards adopted by the State Registrar:

(1) - (2) (No change.)

(3) security thread - micro printed polyester thread that is introduced into the paper during the forming process so that the thread is embedded and is an integral part of the paper;

[(3) a copy void pantograph - the word void appears when the document is photocopied;]

(4) - (13) (No change.)

(d) Other permitted security features. Other security features such as, but not limited to the following, may also be incorporated in the paper used:

(1) (No change.)

(2) a copy void pantograph - the word void appears when the document is photocopied.

[(2) security thread - micro printed polyester thread that is introduced into the paper during the forming process so that the thread is embedded and is an integral part of the paper.]

(e) Record retention. An electronic [A] record or paper application that includes [of] the date issued, document control number, name, [and] address and signature, and a photocopy or facsimile of the form of identification to whom the record was issued shall be made and maintained for a period of three years from the date issued. [The application form, with the document number inserted, used to apply for a record will fulfill this requirement.]

(f) The Vital Statistics Unit will develop standards for procurement parameters regarding the purchase and distribution of the issuing medium for birth certificates, including paper.

(g) The Vital Statistics Unit will explore options regarding establishment of a central database for the issuance of certified copies and abstracts of birth certificates by State and Local Registrars.

(h) The Vital Statistics Unit will develop standards to limit access to archived paper birth certificates and set standards for the paper used to print certified copies and abstracts of birth.

(i) Properly Qualified Applicant Acceptable Documentation.

(1) In accordance with Health and Safety Code, §191.051, "Certified Copies," all lobby and mail-in applications submitted to obtain certified documents must meet the guidelines set out in this rule.

(2) All applicants for certified documents must present proof of identity acceptable to the State Registrar.

(3) All requests for certified documents must be submitted on a state-approved application or in a format that is acceptable to the State Registrar.

(4) All lobby and mail-in applications submitted to obtain certified documents must contain the applicant's signature.

(5) All applicants must sufficiently identify the vital record that is of interest at the time of request.

(6) All primary identification documents must have a United States issuance origin.

(7) All identification documents must be verifiable by the source that issued the document.

(8) The Vital Statistics Unit shall retain a photocopy of all documents submitted and accepted as proof of identification in accordance with the retention period in subsection (e) of this section.

(9) All applicants must present identification consistent with the following identification requirements:

(A) primary identification outlined in paragraph (10) of this subsection; or

(B) secondary identification reflected in paragraph (11) of this subsection; and

(C) supporting documentation stated in paragraph (12) of this subsection.

(10) Primary Identification.

(A) Primary Identification documents do not require supporting instruments, unless otherwise specified.

(B) All acceptable Primary Identification documents must be current and valid.

(C) The applicant's identification must contain the applicant's name and photograph that establishes the applicant's identity.

(D) Acceptable forms of Primary Identification:

(i) Driver's License;

(ii) Federal or State Identification card;

(iii) Federal, State or City law enforcement employment identification card, or employment badge accompanied by employment identification card;

(iv) Offender Identification card issued by the Department of Criminal Justice correctional facility or institution;

(v) Military Identification card;

(vi) Department of Homeland Security, United States Citizenship and Immigration Services (USCIS) issued:

(I) Employment Authorization Document (EAD);

(II) Permanent Resident Card (green card);

(III) Travel Documents:
(-a-) Re-entry Permit;
(-b-) Refugee Travel Permit; or
(-c-) Advance Parole.

(IV) SENTRI Card; or

(V) U.S. Citizen Identification Card.

(vii) United States Department of State issued:

(I) Border Crossing Card (B1 for business or pleasure or B2 medical purposes); or

(II) Visa.

(viii) Concealed Handgun License;

(ix) Pilot's license; or

(x) United States Passport.

(11) Secondary identification.

(A) In the absence of a form of primary identification, applicants are permitted to submit secondary forms of identification to establish proof of their identity.

(B) When submitting secondary forms of identification, applicants are required to produce:

(i) two forms of Acceptable Secondary Identification, of different types; or

(ii) one form of Acceptable Secondary Identification, plus two forms of Acceptable Supporting Identification of different types.

(C) When submitting secondary forms of identification, the documents combined must confirm the identity of the applicant. At least one of the documents must contain the applicant's name, signature, or identifiable photo of the applicant.

(D) Acceptable forms secondary identification:

(i) Current student identification;

(ii) Any Primary Identification that is expired;

(iii) Signed Social Security card, or Numident;

(iv) DD Form 214 Certificate of Release;

(v) Medicaid card;

(vi) Medicare card;

(vii) Veterans Affairs card;

(viii) Medical insurance card;

(ix) Foreign Passport accompanied by a Visa issued by the United States Department of State;

(x) Foreign Passport in accordance with the United States Department of State, Visa Waiver Program;

(xi) Certified birth certificate from the Department of State (FS-240, DS-1350 or FS-545);

(xii) Private Company Employment Identification card;

(xiii) Form I-94 - accompanied by the applicant's Visa or Passport;

(xiv) Mexican voter registration card; or

(xv) Foreign Identification with identifiable photo of applicant.

(12) Supporting Identification--Other records or documents that verify the applicant's identity. The Vital Statistics Unit refers to their policy for acceptable supporting identification. The examining or supervisory personnel may determine that a supporting identification document may meet the department's requirements in establishing identity.

§181.29. Foreign Adoptions.

(a) (No change.)

(b) A certified copy of the decree of adoption granted in a foreign country and information with translation into the English language relating to the adoptive parent(s) and adoptee should be submitted to a court of competent jurisdiction of this state for validation. It is the responsibility of the applicant(s) to have all required documents translated into the English language. An official certificate of adoption must be prepared and submitted to the Vital Statistics Unit [~~Bureau~~] by the clerk of the court validating the foreign adoption.

(c) Certificate of birth. The State Registrar [~~state registrar~~] shall prepare a new certificate of birth for a person born in a foreign country, and adopted under the laws of a foreign country or under the laws of this state, when the State Registrar [~~state registrar~~] receives the following from a resident of this state:

(1) - (3) (No change.)

(d) Guidelines. The State Registrar [~~state registrar~~] shall use the following guidelines when preparing a new certificate of birth.

(1) The State Registrar [~~state registrar~~] shall not alter or change the place of birth or the date of birth from the information contained in the documentation presented.

(2) The new certificate shall be prepared on the current certificate form in the same manner as an in-state adoption is prepared and reflect the foreign country of birth [~~shall bear the title "Certificate of Foreign Birth."~~].

(3) As prescribed in the Health and Safety Code, §192.008, all documentation used to prepare the new certificate of birth shall be placed in a sealed file and accessed by an applicant only upon presentation of a certified copy of an order from the Texas district court that validated the foreign adoption [~~a court of competent jurisdiction~~].

(4) Once a file is sealed, a standard fee shall be charged for a search for a file and any copies of records issued as prescribed in Health and Safety Code, §191.0045.

(e) (No change.)

§181.30. Instructions and Requirements for Filing of Amendments to Medical Certification of Certificate of Death with a Local Registrar.

(a) An amending certificate (medical amendment) may be filed with the appropriate Local Registrar [~~local registrar~~] or State Registrar [~~state registrar~~] electronically through a Vital Statistics Unit [~~Bureau of Vital Statistics~~] electronic death registration system to complete or correct medical certification information on a certificate of death that is incomplete or inaccurate. The medical amendment must be in a format as prescribed by the department.

(b) (No change.)

(c) The registrar shall carefully examine each medical amendment when presented for registration to determine if it is complete as required by the State Registrar's [~~state registrar's~~] instructions.

(d) (No change.)

(e) The registrar shall number the medical amendment with the same file number assigned to the original death certificate. The Local Registrar [~~local registrar~~] shall sign each medical amendment to attest to the date the amendment is filed in the Local Registrar's [~~local registrar's~~] office. The signature may be either electronic, handwritten or a facsimile stamp. The medical amendment shall be attached to and become a part of the legal record of the death if the amendment is accepted for filing.

(f) - (g) (No change.)

§181.31. Minimum Requirements for Adoption Reporting.

(a) The court that renders a decree of adoption shall send to the Vital Statistics Unit [~~Bureau~~] a certificate of adoption on Form VS-160. The clerk of the court shall send the form not later than the 10th day of the first month after the month in which the court renders the adoption decree. The certificate shall include[,] the information as prescribed in Texas Family Code, §108.003.

(b) When the Vital Statistics Unit [~~Bureau~~] determines that a certificate of adoption filed with the State Registrar [~~state registrar~~] requires correction, the Vital Statistics Unit [~~Bureau~~] shall mail the certificate directly to the attorney of record for correction. Upon correction, the attorney shall return the corrected certificate to the Vital Statistics Unit [~~Bureau~~]. If there is no attorney of record, the Vital Statistics Unit [~~Bureau~~] shall mail a photocopy of the certificate to the clerk of the court for correction.

(c) When the clerk of the court collects the $15 fee required by the Texas Family Code, §108.006(b), for each adoption petition filed, the clerk shall attach the fee to the certificate of adoption(s), and forward to the Vital Statistics Unit [~~Bureau~~], as provided in subsection (a) of this section to Vital Statistics Unit - Mail Code 2096 [~~to Bureau of Vital Statistics~~], P.O. Box 12040, Austin, Texas 78711-2040.

§181.32. Maintenance of Out-of-Business Child-Placing Agency Records and Health, Social, Educational and Genetic History Reports.

(a) At or prior to the time a child-placing agency ceases to function as a child-placing agency, it shall notify the Texas Department of State Health Services-Vital Statistics Unit [~~Health-Bureau of Vital Statistics~~], where its adoption records shall be kept for permanent safekeeping.

(b) The Vital Statistics Unit [~~Bureau~~] maintains many records of closed adoption agencies and is one entity a child-placing agency may designate to preserve its adoption records. An agency may also designate another Texas licensed child-placing agency to preserve its records.

(c) If a child-placing agency designates the Vital Statistics Unit [~~Bureau~~] to house its records, the agency shall assume the responsibility of shipping the records to a designation specified by the Vital Statistics Unit [~~Bureau~~]. The agency must ensure that the records are free from insects and rodents, and mildew-free and dry. The records shall be shipped in sturdy cardboard boxes (no larger than 12 inches x 15 inches) via an insured carrier.

(1) (No change.)

(2) The agency must provide two index cards for each adoption file, one that cross-references the birth mother's name with the adoptive parents' and adoptee's name, and one cross-referencing the adoptive parents' names with the birth mother's and adoptee's name. Each card must include the date of birth of each child and the child's adoptive name. The information may also be provided electronically in a format compatible or acceptable to the Vital Statistics Unit's [~~Bureau's~~] standards.

(d) If the child-placing agency designates the Vital Statistics Unit [~~Bureau~~] to maintain and preserve its records, a redacted or de-identified copy of the birth and/or adoption record shall be prepared by the Vital Statistics Unit [~~Bureau~~] for a qualified requestor under the Texas Family Code, §162.018, Access to Information. Charges for copies shall be as allowed by the Open Records Act, Government Code, Chapter 552.

(e) If a birth relative provides post-adoption medical or social information to the Vital Statistics Unit [~~Bureau~~] and the Vital Statistics Unit [~~Bureau~~] houses the records of the closed child-placing agency, the Vital Statistics Unit [~~Bureau~~] may place the information with the original child-placing agency's file. If a birth relative provides post-adoption medical or social information to the Vital Statistics Unit [~~Bureau~~], the adoption occurred outside of a licensed child-placing agency, and the Vital Statistics Unit [~~Bureau~~] readily identifies the sealed adoption file, the Vital Statistics Unit [~~Bureau~~] shall place the updated information in the Health, Social, Education and Genetic History record series in the date received and cross-referenced in the Vital Statistics Unit's [~~Bureau's~~] database.

(1) The Vital Statistics Unit [~~Bureau~~] shall make a diligent effort to locate the last known address of the adoptive parents and attempt to inform them of their right to examine the redacted or de-identified portion of the record.

(2) (No change.)

(f) If a child is biologically unrelated to the prospective adoptive parents and placed outside of a licensed child-placing agency, the adopting attorney shall provide to the Vital Statistics Unit [~~Bureau~~] a copy of the Health, Social, Education and Genetic History report (HSEGH) as prescribed by the Family Code. Within a reasonable amount to time, the Vital Statistics Unit [~~Bureau~~] shall provide a certificate to the adopting attorney acknowledging receipt of the report.

(g) International adoptions. If a child born in a foreign country is placed with prospective adoptive parent(s) who reside in this state and the child is being adopted in this state, the adopting attorney shall file a HSEGH with the Vital Statistics Unit [~~Bureau~~] along with all foreign documents relating to the child's history prior to being placed for adoption, along with each document's English translation. If no information is available about the child prior to placement with its prospective adoptive parent(s), the adopting parents may state that no other information except for the aforementioned documents is available concerning the child's background.

(h) (No change.)

§181.33. Instructions and Requirements for Registering a Certificate of Death by Catastrophe.

(a) No change.)

(b) When catastrophe is deemed the cause of death, the Local Registrar [~~local registrar~~] shall prepare and file the certificate of death.

(c) The Local Registrar [~~local registrar~~] shall only prepare and file a certificate of death caused by catastrophe if:

(1) (No change.)

(2) an affidavit has been submitted to the Local Registrar [~~local registrar~~] according to the guidelines set forth in the Health and Safety Code, §193.010(b), and the affiant has followed the specific criteria laid out in Health and Safety Code, §193.010(b).

(d) The Vital Statistics Unit [~~Bureau~~] may prepare and file a certificate of death by catastrophe for a minor or a person for whom a guardian has been appointed who is the subject of a custody or guardianship dispute only if all parties to the dispute submit an affidavit under the Health and Safety Code, §193.010(b).

(e) A registrar completing a certificate of death that is a death by catastrophe shall complete the cause of death information as follows.

(1) Type the words, "Death by Catastrophe" in item number 33 [~~35~~], Part 1a.

(2) Do not complete the rest of item 33 [~~35~~].

(3) Complete items 36 through 39 [~~40~~] if known.

(4) Items 40a [~~41a~~] through 40f and 41 [~~41f~~] must be completed on all certificates of death by catastrophe.

§181.34. Instructions and Requirements for Reporting Assisted Reproduction Procedures Performed by a Health Care Facility Under a Gestational Agreement.

(a) (No change.)

(b) The Vital Statistics Unit [~~Bureau~~] in accordance with the guidelines of Texas Family Code, §160.763 shall prescribe the form and content of the reporting form.

(c) Reporting healthcare facilities must submit this report to the Vital Statistics Unit [~~Bureau~~] on a yearly basis.

(d) (No change.)

§181.35. Parental Consent of Underage Applicants to Marriage.

(a) The county clerk shall issue a marriage license to an applicant who is 16 years of age or older, but under 18 years of age, if parental consent is given.

(b) A parent or person who has legal authority to consent to marriage for an underage applicant who gives consent shall provide:

(1) proof of the parent's or person's identity; and

(2) proof that the parent or person has the legal authority to consent to marriage for the applicant.

(c) In accordance with Texas Family Code, §2.009(b), proof of the parent's or person's legal identity must be established by:

(1) a driver's license or identification card issued by this state, another state, or a Canadian province that is current or has expired not more than two years preceding the date the identification is

submitted to the county clerk in connection with an application for a license;

(2) a United States passport;

(3) a current passport issued by a foreign country or a consular document issued by a state or national government;

(4) an unexpired Certificate of United States Citizenship, Certificate of Naturalization, United States Citizen Identification Card, Permanent Resident Card, Temporary Resident Card, Employment Authorization Card, or other document issued by the federal Department of Homeland Security or the United States Department of State including an identification photograph;

(5) an unexpired military identification card for active duty, reserve, or retired personnel with an identification photograph;

(6) an original or certified copy of a birth certificate issued by a vital statistics registrar for a state or a foreign government;

(7) an original or certified copy of a Consular Report of Birth Abroad or Certificate of Birth Abroad issued by the United States Department of State;

(8) an original or certified copy of a court order relating to the applicant's name change or sex change;

(9) school records from a secondary school or institution of higher education;

(10) an insurance policy continuously valid for the two years preceding the date of the application for a license;

(11) a motor vehicle certificate of title;

(12) military records, including documentation of release or discharge from active duty or a draft record;

(13) an unexpired military dependent identification card;

(14) an original or certified copy of the applicant's marriage license or divorce decree;

(15) a voter registration certificate;

(16) a pilot's license issued by the Federal Aviation Administration or another authorized agency of the United States;

(17) a license to carry a concealed handgun under Government Code, Chapter 411, Subchapter H;

(18) a temporary driving permit or a temporary identification card issued by the Department of Public Safety; or

(19) an offender identification card issued by the Texas Department of Criminal Justice.

(d) Proof that the parent or person has the legal authority to consent to marriage for the applicant must be in the form of a certified document, which may include:

(1) a certified copy of a birth certificate issued by this state, another state, or a foreign government;

(2) a report of birth abroad;

(3) an adoption decree with adopting parents' names; or

(4) a court order from a court of competent jurisdiction establishing custody or guardianship.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300422
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 776-6972

♦ ♦ ♦

SUBCHAPTER C. CENTRAL ADOPTION REGISTRY

25 TAC §§181.42 - 181.45

STATUTORY AUTHORITY

The amendments are authorized by Health and Safety Code, §191.002, which authorizes rules necessary for the effective administration of Vital Statistics Records; Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the sections implements Government Code, §2001.039.

The amendments affect Health and Safety Code, Chapters 191 and 1001; and Government Code, Chapter 531.

§181.42. Adoption Information by the Courts or Child-Placing Agencies.

(a) At the time an adoption order is rendered, the district court that grants the adoption shall provide to the adoptive parents information provided by the Vital Statistics Unit [~~bureau~~] describing the functions of voluntary adoption registries. If the adopted child is 14 years of age or older, the court shall provide the information to the child.

(b) - (c) (No change.)

§181.43. Requirement to Send Information to the Central Adoption Registry and the Coordination of the Release of Identifying Information with an Authorized Registry.

(a) An authorized voluntary adoption registry shall send to the Central Adoption Registry (CAR) duplicate information of all registrant information it maintains in its registry. This includes all registrant file information and Form VS [~~BVS~~] - 2271. The child-placing agency's adoption case files are not needed, unless the information contained in those files provides information to benefit or aid the match process. Registrant information shall also include proof of age and identity of each registrant, and all known names, dates of birth, and places of birth of each person for whom the registrant is searching, if known. Subsequent documentation including address changes of the registrant received by the registry shall be forwarded to the CAR.

(b) - (c) (No change.)

§181.44. Inquiry through the Central Index.

(a) The Vital Statistics Unit [~~Bureau~~] charges a fee of $5.00 to determine if a child-placing agency that operates its own registry was involved in a specified adoption. An eligible applicant may send the inquiry, along with the appropriate fee and proof of age and identity to the Vital Statistics Unit - Mail Code 2096, Attention: Central Adoption

Registry (CAR), P.O. Box 140123, Austin, Texas 78714-0123 or may inquire in person at the Vital Statistics Unit [~~Bureau of Vital Statistics~~], 1100 West 49th Street, Austin, Texas.

(b) - (c) (No change.)

§181.45. Registration in the Voluntary Adoption Registry System.

(a) To register with the Central Adoption Registry (CAR) or any other authorized registry as defined in Texas Family Code, §162.403(b), a person must comply with the following requirements:

(1) complete registration form (VS [~~BVS~~]- 2271) and any other information the authorized registry deems necessary to identify the person(s) the applicant is searching for. Form VS [~~BVS~~]- 2271 shall provide a space to include the registry's mailing address if different than the CAR; and

(2) - (3) (No change.)

(b) - (c) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300423
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 776-6972

♦ ♦ ♦

SUBCHAPTER D. BIRTH REGISTRATION CERTIFICATION

25 TAC §§181.50 - 181.54

STATUTORY AUTHORITY

The new rules are authorized by Health and Safety Code, §191.002, which authorizes rules necessary for the effective administration of Vital Statistics Records; Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the sections implements Government Code, §2001.039.

The new rules affect Health and Safety Code, Chapters 191 and 1001; and Government Code, Chapter 531.

§181.50. Scope.

The purpose of this Subchapter is to establish certification requirements for the person required to register the birth of a child in this state as set forth by Health and Safety Code, Chapter 192, Subchapter A, General Registration Provisions. The person required to register the birth of a child in this state must meet the requirements of the birth registrar certification and must abide by the rules of this subchapter.

§181.51. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Acknowledgment of Paternity Training--Training from the Office of the Attorney General as prescribed in 1 TAC Chapter 55, concerning Child Support Enforcement.

(2) Application for Birth Registrar Certification/Re-certification--An online application prescribed and provided by the Vital Statistics Unit to assess the knowledge and skills of a birth registrar.

(3) Birth registrar--Person responsible for filing a birth certificate as prescribed in Health and Safety Code, §192.003(a) and (b).

(4) Birth Registrar Certification (BRC)--A certification program required for all birth registrars.

(5) Certification period--The certification period two years from certification date.

(6) Continuing education--Educational training that contributes to the advancement, extension, and enhancement of the professional skills and knowledge of the birth registrar in the practice of registering births in this state and be open to all birth registrars.

(7) Hour of continuing education--A 50 minute clock hour completed by a birth registrar in attendance at an approved continuing education program.

(8) Midwife--An individual currently licensed under the Texas Board of Nursing as an Advanced Practice Registered Nurse as defined in 22 TAC Chapter 222, or an individual currently licensed with the Texas Midwifery Board to legally practice midwifery in this state.

(9) Physician--An individual currently licensed under the Texas Medical Board to actively practice medicine in this state.

(10) Texas Electronic Registrar (TER) - Birth Registration Online Training Course--An online birth training provided by the Vital Statistics Unit.

§181.52. Certification Requirements and Procedures.

(a) Certification Required. A birth registrar may not complete any aspect of the birth registration process without holding a current certification issued by the Vital Statistics Unit.

(b) Certification Process. Certification for Birth Registrars requires the completion of the following:

(1) Acknowledgment of Paternity training course;

(2) TER - Birth Registration online training course;

(3) be a TER user with an individual User Identification and password;

(4) oath of confidentiality (on file at facility);

(5) a completed Application for Birth Registrar Certification/Re-certification; and

(6) physicians, midwives or persons acting as midwives must provide current licensing information with their respective licensing bodies.

(c) Re-certification Process. Birth registrars who actively register births in this state are required to obtain 8 hours of continuing education every two-year renewal period.

(d) The certification renewal period issued under subsection (a) of this section is two years beginning on the 1st day of the month following the issuance of the certification to the birth registrar.

(e) Birth registration processes occurring at facilities or by midwives may be inspected upon the submission of an Application for Birth Registrar Certification/Re-certification.

(f) Certain Grounds for Denial or Revocation of a Certification are as follows. The Vital Statistics Unit may refuse to issue a new certification or to renew a certification or may revoke a certification of a birth registrar if it determines that the certification application contains false information, or has violated the electronic registration user agreement as prescribed by §181.13 of this title (relating to Birth Certificate Form and Consent).

§181.53. Continuing Education.

(a) Purpose. Each birth registrar holding an active certification and registering births in this state is required to participate in continuing education as a condition of certification renewal.

(b) Credit hours required.

(1) Birth registrars who actively register births in this state are required to obtain 8 hours of continuing education every two-year renewal period. A birth registrar may receive credit for a course only once during a renewal period.

(2) The following are mandatory continuing education hours and subjects for each renewal period.

(A) Electronic Registration - 1 credit hours. This course must at least cover principals of electronic birth registration for this state.

(B) Other training - 7 credit hours. These approved courses should cover laws, rules, best practices, policies and procedures relevant to the registration of births in this state.

(3) It is the responsibility of the licensee to track the number of hours accumulated during a certification period.

(4) Failure to comply. The Vital Statistics Unit will not renew the certification of an individual who fails to obtain the continuing education requirements of this section.

(5) Any birth registrar receiving credit for continuing education obtained fraudulently shall be reported and/or investigated by the State Registrar or the State Registrar's representative and, if necessary, shall report a violation of this section to the appropriate district or county attorney for prosecution.

§181.54. Application for Birth Registrar Certification/Re-Certification.

(a) Each birth registrar must complete an online Application for Birth Registrar Certification/Re-Certification provided by the Vital Statistics Unit.

(b) The completed Application for Birth Registrar Certification/Re-Certification must be submitted, along with the other certification requirements set forth by this subchapter, on or before the end of the certification renewal period.

(c) Each birth registrar must permanently retain a completed copy of the Application for Birth Registrar Certification/Re-Certification. This retention may be in an electronic format.

(d) Birth registrars knowingly making a false statement on the Application for Birth Registrar Certification/Re-Certification will be subject to immediate revocation of their certification and have their electronic registration privileges revoked.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300425
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 776-6972

♦ ♦ ♦

SUBCHAPTER E. DELAYED REGISTRATION

25 TAC §§181.60 - 181.65

STATUTORY AUTHORITY

The new rules are authorized by Health and Safety Code, §191.002, which authorizes rules necessary for the effective administration of Vital Statistics Records; Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the sections implements Government Code, §2001.039.

The new rules affect Health and Safety Code, Chapters 191 and 1001; and Government Code, Chapter 531.

§181.60. Delayed Certification of Birth.

(a) When a certificate of birth of a person born in this state has not been registered before the one-year anniversary of the date of birth, a delayed certificate of birth may be submitted in accordance with regulations of the Vital Statistics Unit. No delayed certificate of birth shall be registered until the evidentiary requirements as specified in regulation have been met.

(b) A certificate of birth submitted under this section shall be marked "Delayed" and show the date of registration. The delayed certificate of birth shall contain a summary statement of the evidence submitted in support of the delayed registration. Probate records and delayed records may not be abstracted.

(c) An application to file a delayed certificate of birth for a birth in this state not registered before the one-year anniversary of the date of birth shall be made to the State Registrar.

(d) No delayed certificate of birth shall be registered for a deceased person.

(e) When an applicant as defined by regulation does not submit the minimum documentation required in the regulations for delayed registration or when the State Registrar has cause to question the validity or adequacy of the applicant's (sworn, notarized, witnessed) statement or the documentary evidence, and if the deficiencies are not corrected, the State Registrar shall not register the delayed certificate of birth. The State Registrar shall advise the applicant of the reasons for this action, and shall further advise the applicant of his or her right to file a petition in the county probate court of the county in which the birth occurred for an order establishing a record of the person's date of birth, place of birth, and parentage.

(f) The State Registrar may provide for the dismissal of an application that is not actively pursued.

§181.61. Who May Request the Registration of a Delayed Certificate of Birth.

(a) Any person 18 years of age or older born in the State of Texas whose birth is not recorded in this state may request the registration of a delayed certificate of birth, subject to these regulations and

instructions issued by the State Registrar. The information on the form must be subscribed and sworn to, before an official authorized to administer oaths, by:

(1) the person whose birth is to be registered; or

(2) the person's parent, legal guardian, or legal representative if the person is incompetent to swear to the information.

(b) Each application for a delayed certificate of birth shall be signed and sworn to, before an official authorized to administer oaths, by the person whose birth is to be registered if such person is 18 years of age or over and is competent to sign and swear to the accuracy of the facts stated therein; otherwise the application shall be signed and sworn to by the person's parent, legal guardian, or legal representative if the person is incompetent to swear to the information.

§181.62. Documentary Evidence; Requirements and Acceptability.

(a) To be acceptable for registration, the name of the person at the time of the birth and the date and place of birth entered on a delayed registration of birth shall be supported by at least:

(1) one piece of acceptable documentary evidence that will establish to the satisfaction of the State Registrar the name of the parent(s);

(2) three pieces of acceptable documentary evidence that will establish to the satisfaction of the State Registrar the facts and date of birth as alleged in the application; and

(3) facts of parentage shall be supported by at least one document.

(b) The State Registrar shall determine the acceptability of all documentary evidence submitted.

(1) Documents must be from independent sources and shall be in the form of the original record or a duly certified copy thereof or a signed statement from the custodian of the record or document.

(2) Documents may include but are not limited to:

(A) census records;

(B) hospital records;

(C) military records;

(D) Social Security records;

(E) school records; or

(F) other documents as designated by the State Registrar.

(3) For persons 15 years of age or older, all documents submitted in evidence, other than an affidavit of personal knowledge, must be at least 5 years old.

(4) At least 1 document submitted in evidence should have been created within the first 10 years of life.

(5) Documents shall not be contradictory.

§181.63. Abstraction of Documentary Evidence.

(a) The State Registrar or his or her designated representative shall abstract on the delayed certificate of birth a description of each document submitted to support the facts. This description shall include:

(1) the title or description of the document;

(2) the name and address of the custodial organization, if any;

(3) the creation date of the original document; and

(4) all birth facts required by §181.62 of this title (relating to Documentary Evidence; Requirements and Acceptability) contained in each document accepted as evidence.

(b) Original documents submitted in support of the delayed certificate of birth shall be returned to the applicant after review. Copies of all items submitted shall be maintained and indexed by the State Registrar.

§181.64. Verification by the State Registrar.

The State Registrar, or his or her designated representative, shall verify:

(1) that no prior certificate of birth is registered in this state for the person whose birth is to be recorded;

(2) that he or she has reviewed the evidence submitted to establish the facts of birth; and

(3) that the abstract of the evidence appearing on the delayed certificate of birth accurately reflects the nature and content of the document.

§181.65. Dismissal After One Year.

An application for a delayed certificate of birth that has not been completed within one year from the date of application may be dismissed at the discretion of the State Registrar. Upon dismissal, the State Registrar shall so advise the applicant and documents submitted in support of such registration shall be returned to the applicant.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300426
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 776-6972

♦ ♦ ♦

TITLE 30. ENVIRONMENTAL QUALITY

PART 1. TEXAS COMMISSION ON ENVIRONMENTAL QUALITY

CHAPTER 297. WATER RIGHTS, SUBSTANTIVE

SUBCHAPTER A. DEFINITIONS AND APPLICABILITY

30 TAC §297.1

The Texas Commission on Environmental Quality (TCEQ, agency, or commission) proposes to amend §297.1.

Background and Summary of the Factual Basis for the Proposed Rule

On June 21, 2012, Bickerstaff Heath Delgado Acosta LLP submitted a rulemaking petition on behalf of the City of Irving (Project Number 2012-034-PET-NR). In their petition, the City of Irving requested that the commission amend the definition of "Munici-

pal use" in §297.1(32) to allow indirect reuse of treated wastewater effluent, referred to hereinafter as use of return flows, for watering of parks, golf courses, and parkways as a municipal use, after that use of return flows has been authorized by the commission. At the TCEQ's agenda on August 8, 2012, the commission approved the initiation of a rulemaking based on this petition.

As requested in the petition, the commission proposes to amend the definition of "Municipal use" to add a reference to the use of return flows in addition to reclaimed water for the uses authorized by the existing rule. The commission also proposes to expand the authorized uses to include watering of other public or recreational spaces and proposes to reference Texas Water Code (TWC), §11.042, since authorizations for the use of return flows are issued by the commission under this statute.

Section Discussion

§297.1, Definitions

The existing definition of "Municipal use" in §297.1(32) allows for the use of reclaimed water in lieu of potable water for domestic, recreational, commercial, or industrial purposes or for the watering of golf courses, parks and parkways. The commission proposes to amend §297.1(32) to change the definition of municipal use to add watering of "other public or recreational spaces" to the list of authorized water uses and to allow use of return flows authorized pursuant to TWC, §11.042, for all of those uses. Other public or recreational spaces could include areas such as athletic fields, neighborhood common areas, and other spaces within a community or municipality and its environs with public uses. The definition of reclaimed water in §297.1(39) requires that its quality be suitable for its intended use. Similarly, proposed §297.1(32)(C) includes language to ensure that any return flows diverted under this rule that are intended for human consumption as defined in §290.38(32) are of suitable quality for their intended use.

Under a revised definition of municipal use, certain water needs could be satisfied by non-potable return flows, preserving potable supplies for human consumption. Additionally, municipal water right holders could gain the flexibility to use permitted return flows for public purposes without the expense of treating the water to make it potable or the expense of amending existing permits for the use of return flows to add irrigation use. The use of return flows is a water planning strategy being explored by many municipal water right holders to stretch existing supplies. The change proposed in this rule could help enable municipal water right holders to implement that strategy. To accommodate these changes, the commission also proposes to reformat the proposed rule language by re-lettering and re-numbering the existing language. The commission proposes the amendment based on a petition for rulemaking.

Fiscal Note: Costs to State and Local Government

Jeffrey Horvath, Analyst in the Strategic Planning and Assessment Section, has determined that for the first five-year period the proposed rule is in effect, no significant fiscal implications are anticipated for the agency or other units of state or local government as a result of administration or enforcement of the proposed rule.

The proposed rule would amend the definition of "Municipal use" to expand the authorized uses of treated wastewater effluent to include watering of public or recreational spaces other than golf courses, parks, and parkways. The proposed change also would reference TWC, §11.042, since authorizations for the use of return flows are issued by the commission under this statute. The proposed rule will allow those with existing authorizations to use return flows to irrigate other public or recreational spaces without having to amend their water right permit.

Currently, there are approximately 48 authorizations for use of return flows. Only 11 of these 48 authorizations currently do not have authority for irrigation. The other 37 authorizations currently have irrigation use authorized. All 11 of the authorizations are held by governmental entities.

Those governmental entities with the 11 authorizations would gain the flexibility to use permitted return flows for public purposes without the expense of amending existing permits for the use of return flows to add irrigation use. Under the proposed rule, permit holders would not have to fill out an application for additional irrigation use, submit the $100 application fee, or treat the water to make it potable. Cost savings for these permit holders and any future applicants for permits for use of return flows are not expected to be significant. Under the proposed rule, the agency may process fewer permit amendments, but any revenue loss is not expected to be significant.

Public Benefits and Costs

Mr. Horvath has also determined that for each year of the first five years the proposed rule is in effect, the public benefit anticipated from the change seen in the proposed rule will be continued protection of the environment and public health while allowing municipal water right holders to explore the use of return flows as a water planning strategy to stretch existing water supplies.

No fiscal implications are anticipated for individuals, and no significant fiscal implications are anticipated for businesses as a result of the implementation or administration of the proposed rule. Any business that obtains a municipal permit for the use of return flows will not have to incur the cost to amend that permit for irrigation of other public or recreational spaces, nor will they have to treat the water to make it potable. These cost savings are not expected to be significant. However, there may be additional cost savings from using water reuse as a strategy to conserve existing water supplies.

Small Business and Micro-Business Assessment

No adverse fiscal implications are anticipated for small or micro-businesses as a result of the administration or enforcement of the proposed rule. Businesses that obtain municipal permits for the use of return flows will not have to incur the cost to amend those permits nor will they have to treat non-potable water if they choose to irrigate other public or recreational spaces. These cost savings are not expected to be significant.

Small Business Regulatory Flexibility Analysis

The commission has reviewed this proposed rulemaking and determined that a small business regulatory flexibility analysis is not required because the proposed rule does not adversely affect a small or micro-business in a material way for the first five years that the proposed rule is in effect.

Local Employment Impact Statement

The commission has reviewed this proposed rulemaking and determined that a local employment impact statement is not required because the proposed rule does not adversely affect a local economy in a material way for the first five years that the proposed rule is in effect.

Draft Regulatory Impact Analysis Determination

The commission reviewed the proposed rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking is not subject to §2001.0225. "Major environmental rule" means a rule the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure, and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state.

First, the proposed rulemaking does not meet the statutory definition of a "major environmental rule" because its specific intent is not to protect the environment or reduce risks to human health from environmental exposure. The specific intent of the proposed rulemaking is to expand the definition of municipal use to include the use of return flows for certain purposes.

Second, the proposed rulemaking does not meet the statutory definition of a "major environmental rule" because the proposed rule would not adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. It is not anticipated that the cost of complying with the proposed rule would be significant with respect to the economy as a whole or with respect to a sector of the economy; therefore, the proposed amendment will not adversely affect in a material way the economy, a sector of the economy, productivity, competition, or jobs.

Written comments on the draft regulatory impact analysis determination may be submitted to the contact person at the address listed under the Submittal of Comments section of this preamble.

Takings Impact Assessment

The commission evaluated this proposed rulemaking and performed an assessment of whether the proposed rule constitutes a taking under Texas Government Code, Chapter 2007. The commission proposed the rule for the specific purpose of clarifying that use of return flows for purposes already identified in the existing definition qualifies as municipal use. In all instances, a municipality operating under this rule amendment will be exercising control over property already belonging to it pursuant to an authorization to use return flows issued by the TCEQ.

A "taking" under Texas Government Code, Chapter 2007 means a governmental action that affects private real property in a manner that requires compensation to the owner under the United States or Texas Constitution, or a governmental action that affects real private property in a manner that restricts or limits the owner's right to the property and reduces the market value of affected real property by at least 25%.

Because no taking of private real property will occur by amending the definitions as proposed, the commission has determined that promulgation and enforcement of the proposed rule would be neither a statutory nor a constitutional taking of private real property. Specifically, there are no burdens imposed on private real property under the rule because the proposed rule neither relates to, nor has any impact on, the use or enjoyment of private real property, and there would be no reduction in real property value as a result of the rule. Therefore, the proposed rule would not constitute a taking under Texas Government Code, Chapter 2007.

Consistency with the Coastal Management Program

The commission reviewed the proposed rulemaking and found the proposal is a rulemaking identified in the Coastal Coordination Act Implementation Rule, 31 TAC §505.11(b)(4), relating to Actions and Rules Subject to the Coastal Management Program, and will, therefore, require that the goals and policies of the Texas Coastal Management Program (CMP) be considered during the rulemaking process.

The commission reviewed this rulemaking for consistency with the CMP goals and policies in accordance with the regulations of the Coastal Coordination Advisory Committee and determined that the rulemaking is administrative in nature and will have no substantive effect on commission actions subject to the CMP and is, therefore, consistent with CMP goals and policies.

Written comments on the consistency of this rulemaking may be submitted to the contact person at the address listed under the Submittal of Comments section of this preamble.

Announcement of Hearing

The commission will hold a public hearing on this proposal in Austin on March 12, 2013 at 10:00 a.m. in Building E, Room 201S, at the commission's central office located at 12100 Park 35 Circle. The hearing is structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. Open discussion will not be permitted during the hearing; however, commission staff members will be available to discuss the proposal 30 minutes prior to the hearing.

Persons who have special communication or other accommodation needs who are planning to attend the hearing should contact Sandy Wong, Office of Legal Services, at (512) 239-1802. Requests should be made as far in advance as possible.

Submittal of Comments

Written comments may be submitted to Michael Parrish, MC 205, Office of Legal Services, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087, or faxed to (512) 239-4808. Electronic comments may be submitted at: *http://www5.tceq.texas.gov/rules/ecomments/.* File size restrictions may apply to comments being submitted via the eComments system. All comments should reference Rule Project Number 2012-039-297-OW. The comment period closes March 18, 2013. Copies of the proposed rulemaking can be obtained from the commission's Web site at *http://www.tceq.texas.gov/nav/rules/propose_adopt.html.* For further information, please contact Jennifer Allis, Water Rights Permitting and Availability Section, at (512) 239-0027.

STATUTORY AUTHORITY

The amendment is proposed under Texas Water Code (TWC), §5.102, which establishes the commission's general authority necessary to carry out its jurisdiction; §5.103, which establishes the commission's general authority to adopt rules; and §5.105, which establishes the commission's authority to set policy by rule.

The proposed rule implements TWC, §§5.102, 5.103, and 5.105.

§297.1. Definitions.

The following words and terms, when used in this chapter and in Chapters 288 and 295 of this title (relating to Water Conservation Plans, Drought Contingency Plans, Guidelines and Requirements; and Water Rights, Procedural, respectively), shall have the following meanings, unless the context clearly indicates otherwise.

(1) Agriculture or agricultural--means any of the following activities:

(A) cultivating the soil to produce crops for human food, animal feed, or planting seed or for the production of fibers;

(B) the practice of floriculture, viticulture, silviculture, and horticulture, including the cultivation of plants in containers or non-soil media by a nursery grower;

(C) raising, feeding, or keeping animals for breeding purposes or for the production of food or fiber, leather, pelts, or other tangible products having a commercial value;

(D) raising or keeping equine animals;

(E) wildlife management;

(F) planting cover crops, including cover crops cultivated for transplantation, or leaving land idle for the purpose of participating in any governmental program or normal crop or livestock rotation procedure; and

(G) aquaculture as defined in Texas Agriculture Code, §134.001, which reads "'aquaculture' or 'fish farming' means the business of producing and selling cultured species raised in private facilities. Aquaculture or fish farming is an agricultural activity."

(2) Agricultural use--Any use or activity involving agriculture, including irrigation.

(3) Appropriations--The process or series of operations by which an appropriative right is acquired. A completed appropriation thus results in an appropriative right; the water to which a completed appropriation in good standing relates is appropriated water.

(4) Appropriative right--The right to impound, divert, store, take, or use a specific quantity of state water acquired by law.

(5) Aquifer Storage and Retrieval Project--A project with two phases that anticipates the use of a Class V aquifer storage well, as defined in §331.2 of this title (relating to Definitions), for injection into a geologic formation, group of formations, or part of a formation that is capable of underground storage of appropriated surface water for subsequent retrieval and beneficial use. Phase I of the project requires commission authorization by a temporary or term permit to determine feasibility for ultimate storage and retrieval for beneficial use. Phase II of the project requires commission authorization by permit or permit amendment after the commission has determined that Phase I of the project has been successful.

(6) Baseflow or normal flow--The portion of streamflow uninfluenced by recent rainfall or flood runoff and is comprised of springflow, seepage, discharge from artesian wells or other groundwater sources, and the delayed drainage of large lakes and swamps. (Accountable effluent discharges from municipal, industrial, agricultural, or other uses of ground or surface waters may be included at times.)

(7) Beneficial inflows--Freshwater inflows providing for a salinity, nutrient, and sediment loading regime adequate to maintain an ecologically sound environment in the receiving bay and estuary that is necessary for the maintenance of productivity of economically important and ecologically characteristic sport or commercial fish and shellfish species and estuarine life upon which such fish and shellfish are dependent.

(8) Beneficial use--Use of the amount of water which is economically necessary for a purpose authorized by law, when reasonable intelligence and reasonable diligence are used in applying the water to that purpose and shall include conserved water.

(9) Certificate of adjudication--An instrument evidencing a water right issued to each person adjudicated a water right in conformity with the provisions of Texas Water Code, §11.323, or the final judgment and decree in State of Texas v. Hidalgo County Water Control and Improvement District No. 18, 443 S.W.2d 728 (Texas Civil Appeals - Corpus Christi 1969, writ ref. n.r.e.).

(10) Certified filing--A declaration of appropriation or affidavit which was filed with the State Board of Water Engineers under the provisions of the 33rd Legislature, 1913, General Laws, Chapter 171, §14, as amended.

(11) Claim--A sworn statement filed under Texas Water Code, §11.303.

(12) Commencement of construction--An actual, visible step beyond planning or land acquisition, which forms the beginning of the on-going (continuous) construction of a project in the manner specified in the approved plans and specifications, where required, for that project. The action must be performed in good faith with the bona fide intent to proceed with the construction.

(13) Conservation--Those practices, techniques, and technologies that will reduce the consumption of water, reduce the loss or waste of water, improve the efficiency in the use of water, or increase the recycling and reuse of water so that a water supply is made available for future or alternative uses.

(14) Conserved water--That amount of water saved by a water right holder through practices, techniques, or technologies that would otherwise be irretrievably lost to all consumptive beneficial uses arising from the storage, transportation, distribution, or application of the water. Conserved water does not mean water made available simply through its non-use without the use of such practices, techniques, or technologies.

(15) Dam--Any artificial structure, together with any appurtenant works, which impounds or stores water. All structures which are necessary to impound a single body of water shall be considered as one dam. A structure used only for diverting water from a watercourse by gravity is a diversion dam.

(16) Diffused surface water--Water on the surface of the land in places other than watercourses. Diffused water may flow vagrantly over broad areas coming to rest in natural depressions, playa lakes, bogs, or marshes. (An essential characteristic of diffused water is that its flow is short-lived.)

(17) District--Any district or authority created by authority of the Texas Constitution, either Article III, §52, (b), (1) and (2), or Article XVI, §59.

(18) Domestic use--Use of water by an individual or a household to support domestic activity. Such use may include water for drinking, washing, or culinary purposes; for irrigation of lawns, or of a family garden and/or orchard; for watering of domestic animals; and for water recreation including aquatic and wildlife enjoyment. If the water is diverted, it must be diverted solely through the efforts of the user. Domestic use does not include water used to support activities for which consideration is given or received or for which the product of the activity is sold.

(19) Drought of record--The historic period of record for a watershed in which the lowest flows were known to have occurred based on naturalized streamflow.

(20) Firm yield--That amount of water, that the reservoir could have produced annually if it had been in place during the worst drought of record. In performing this simulation, naturalized streamflows will be modified as appropriate to account for the full exercise of

upstream senior water rights is assumed as well as the passage of sufficient water to satisfy all downstream senior water rights valued at their full authorized amounts and conditions as well as the passage of flows needed to meet all applicable permit conditions relating to instream and freshwater inflow requirements.

(21) Groundwater--Water under the surface of the ground other than underflow of a stream and underground streams, whatever may be the geologic structure in which it is standing or moving.

(22) Habitat Mitigation--Actions taken to off-set anticipated adverse environmental impacts from a proposed project. Such actions and their sequence include:

(A) avoiding the impact altogether by not taking a certain action or parts of an action or pursuing a reasonably practicable alternative;

(B) minimizing impacts by limiting the degree or magnitude of the action and its implementation;

(C) rectifying the impact by repairing, rehabilitating, or restoring the affected environment;

(D) reducing or eliminating the impact over time by preservation and maintenance operations during the life of the project; and

(E) compensating for the impact by replacing or providing substitute resources or environments.

(23) Hydropower use--The use of water for hydroelectric and hydromechanical power and for other mechanical devices of like nature.

(24) Industrial use--The use of water in processes designed to convert materials of a lower order of value into forms having greater usability and commercial value, including the development of power by means other than hydroelectric, but does not include agricultural use.

(25) Instream use--The beneficial use of instream flows for such purposes including, but not limited to, navigation, recreation, hydropower, fisheries, game preserves, stock raising, park purposes, aesthetics, water quality protection, aquatic and riparian wildlife habitat, freshwater inflows for bays and estuaries, and any other instream use recognized by law. An instream use is a beneficial use of water. Water necessary to protect instream uses for water quality, aquatic and riparian wildlife habitat, recreation, navigation, bays and estuaries, and other public purposes may be reserved from appropriation by the commission.

(26) Irrigation--The use of water for the irrigation of crops, trees, and pasture land, including, but not limited to, golf courses and parks which do not receive water through a municipal distribution system.

(27) Irrigation water efficiency--The percentage of that amount of irrigation water which is beneficially used by agriculture crops or other vegetation relative to the amount of water diverted from the source(s) of supply. Beneficial uses of water for irrigation purposes include but are not limited to evapotranspiration needs for vegetative maintenance and growth and salinity management and leaching requirements associated with irrigation.

(28) Livestock use--The use of water for the open-range watering of livestock, exotic livestock, game animals or fur-bearing animals. For purposes of this definition, the terms livestock and exotic livestock are to be used as defined in §142.001 of the Agriculture Code, and the terms game animals and fur-bearing animals are to be used as defined in §63.001 and §71.001, respectively, of the Parks and Wildlife Code.

(29) Mariculture--The propagation and rearing of aquatic species, including shrimp, other crustaceans, finfish, mollusks, and other similar creatures in a controlled environment using brackish or marine water.

(30) Mining use--The use of water for mining processes including hydraulic use, drilling, washing sand and gravel, and oil field repressuring.

(31) Municipal per capita water use--The sum total of water diverted into a water supply system for residential, commercial, and public and institutional uses divided by actual population served.

(32) Municipal use--

(A) The use of potable water within a community or municipality and its environs for domestic, recreational, commercial, or industrial purposes or for the watering of golf courses, parks and parkways, other public or recreational spaces; or

(B) the use of reclaimed water in lieu of potable water for the preceding purposes; or

(C) the use of return flows authorized pursuant to Texas Water Code, §11.042, in lieu of potable water for the preceding purposes. Return flows used for human consumption as defined in §290.38(32) of this title (relating to Definitions) must be of a quality suitable for the authorized beneficial use as may be required by applicable commission rules; or

(D) the application of municipal sewage effluent on land, under a Texas Water Code, Chapter 26, permit where:

(i) [~~(A)~~] the application site is land owned or leased by the Chapter 26 permit holder; or

(ii) [~~(B)~~] the application site is within an area for which the commission has adopted a no-discharge rule.

(33) Navigable stream--By law, Natural Resources Code, §21.001(3), any stream or streambed as long as it maintains from its mouth upstream an average width of 30 feet or more, at which point it becomes statutorily nonnavigable.

(34) Nursery grower--A person engaged in the practice of floriculture, viticulture, silviculture, and horticulture, including the cultivation of plants in containers or nonsoil media, who grows more than 50% of the products that the person either sells or leases, regardless of the variety sold, leased, or grown. For the purpose of this definition, grow means the actual cultivation or propagation of the product beyond the mere holding or maintaining of the item prior to sale or lease and typically includes activities associated with the production or multiplying of stock such as the development of new plants from cuttings, grafts, plugs, or seedlings.

(35) One-hundred-year flood--The flood peak discharge of a stream, based upon statistical data, which would have a 1.0% chance of occurring in any given year.

(36) Permit--The authorization by the commission to a person whose application for a permit has been granted. A permit also means any water right issued, amended, or otherwise administered by the commission unless the context clearly indicates that the water right being referenced is being limited to a certificate of adjudication, certified filing, or unadjudicated claim.

(37) Pollution--The alteration of the physical, thermal, chemical, or biological quality of, or the contamination of any water in the state that renders the water harmful or detrimental to humans,

animal life, vegetation, or property, or the public health, safety or welfare, or impairs the usefulness of the public enjoyment of the waters for any lawful or reasonable purpose.

(38) Priority--As between appropriators, the first in time is the first in right, Texas Water Code, §11.027, unless determined otherwise by an appropriate court or state law.

(39) Reclaimed water--Municipal or industrial wastewater or process water that is under the direct control of the treatment plant owner/operator, or agricultural tailwater that has been collected for reuse, and which has been treated to a quality suitable for the authorized beneficial use.

(40) Recreational use--The use of water impounded in or diverted or released from a reservoir or watercourse for fishing, swimming, water skiing, boating, hunting, and other forms of water recreation, including aquatic and wildlife enjoyment, and aesthetic land enhancement of a subdivision, golf course, or similar development.

(41) Register--The *Texas Register*.

(42) Reservoir system operations--The coordinated operation of more than one reservoir or a reservoir in combination with a direct diversion facility in order to optimize available water supplies.

(43) Return water or return flow--That portion of state water diverted from a water supply and beneficially used which is not consumed as a consequence of that use and returns to a watercourse. Return flow includes sewage effluent.

(44) Reuse--The authorized use for one or more beneficial purposes of use of water that remains unconsumed after the water is used for the original purpose of use and before that water is either disposed of or discharged or otherwise allowed to flow into a watercourse, lake, or other body of state-owned water.

(45) River basin--A river or coastal basin designated by the Texas Water Development Board as a river basin under Texas Water Code, §16.051. The term does not include waters originating in bays or arms of the Gulf of Mexico.

(46) Runoff--That portion of streamflow comprised of surface drainage or rainwater from land or other surfaces during or immediately following a rainfall.

(47) Secondary use--The reuse of state water for a purpose after the original, authorized use.

(48) Sewage or sewage effluent--Water-carried human or animal wastes from residences, buildings, industrial establishments, cities, towns, or other places, together with any groundwater infiltration and surface waters with which it may be commingled.

(49) Spreader dam--A levee-type embankment placed on alluvial fans or within a flood plain of a watercourse, common to land use practices, for the purpose of overland spreading of diffused waters and overbank flows.

(50) State water--The water of the ordinary flow, underflow, and tides of every flowing river, natural stream, and lake, and of every bay or arm of the Gulf of Mexico, and the stormwater, floodwater, and rainwater of every river, natural stream, and watercourse in the state. State water also includes water which is imported from any source outside the boundaries of the state for use in the state and which is transported through the beds and banks of any navigable stream within the state or by utilizing any facilities owned or operated by the state. Additionally, state water injected into the ground for an aquifer storage and recovery project remains state water. State water does not include percolating groundwater; nor does it include diffuse surface rainfall runoff, groundwater seepage, or springwater before it reaches a watercourse.

(51) Stormwater or floodwater--Water flowing in a watercourse as the result of recent rainfall.

(52) Streamflow--The water flowing within a watercourse.

(53) Surplus water--Water taken from any source in excess of the initial or continued beneficial use of the appropriator for the purpose or purposes authorized by law. Water that is recirculated within a reservoir for cooling purposes shall not be considered to be surplus water.

(54) Unappropriated water--The amount of state water remaining in a watercourse or other source of supply after taking into account complete satisfaction of all existing water rights valued at their full authorized amounts and conditions.

(55) Underflow of a stream--Water in sand, soil, and gravel below the bed of the watercourse, together with the water in the lateral extensions of the water-bearing material on each side of the surface channel, such that the surface flows are in contact with the subsurface flows, the latter flows being confined within a space reasonably defined and having a direction corresponding to that of the surface flow.

(56) Waste--The diversion of water if the water is not used for a beneficial purpose; the use of that amount of water in excess of that which is economically reasonable for an authorized purpose when reasonable intelligence and reasonable diligence are used in applying the water to that purpose. Waste may include, but not be limited to, the unreasonable loss of water through faulty design or negligent operation of a water delivery, distribution or application system, or the diversion or use of water in any manner that causes or threatens to cause pollution of water. Waste does not include the beneficial use of water where the water may become polluted because of the nature of its use, such as domestic or residential use, but is subsequently treated in accordance with all applicable rules and standards prior to its discharge into or adjacent to water in the state so that it may be subsequently beneficially used.

(57) Water conservation plan--A strategy or combination of strategies for reducing the volume of water withdrawn from a water supply source, for preventing or reducing the loss or waste of water, for maintaining or improving the efficiency in the use of water, for increasing the recycling and reuse of water, and for preventing the pollution of water. A water conservation plan may be a separate planning document or may be contained within another water management document(s).

(58) Water in the state--Groundwater, percolating or otherwise, lakes, bays, ponds, impounding reservoirs, springs, rivers, streams, creeks, estuaries, marshes, inlets, canals, the Gulf of Mexico inside the territorial limits of the state, and all other bodies of surface water, natural or artificial, inland or coastal, fresh or salt, navigable or nonnavigable, and including the beds and banks of all watercourses and bodies of surface water, that are wholly or partially inside or bordering the state or inside the jurisdiction of the state.

(59) Watercourse--A definite channel of a stream in which water flows within a defined bed and banks, originating from a definite source or sources. (The water may flow continuously or intermittently, and if the latter with some degree of regularity, depending on the characteristics of the sources.)

(60) Water right--A right or any amendment thereto acquired under the laws of this state to impound, divert, store, convey, take, or use state water.

(61) Watershed--A term used to designate the area drained by a stream and its tributaries, or the drainage area upstream from a specified point on a stream.

(62) Water supply--Any body of water, whether static or moving, either on or under the surface of the ground, available for beneficial use on a reasonably dependable basis.

(63) Wetland--An area (including a swamp, marsh, bog, prairie pothole, playa, or similar area) having a predominance of hydric soils that are inundated or saturated by surface or groundwater at a frequency and duration sufficient to support and that under normal circumstances supports the growth and regeneration of hydrophytic vegetation. The term "hydric soil" means soil that, in its undrained condition is saturated, flooded, or ponded long enough during a growing season to develop an anaerobic condition that supports the growth and regeneration of hydrophytic vegetation. The term "hydrophytic vegetation" means a plant growing in water or a substrate that is at least periodically deficient in oxygen during a growing season as a result of excessive water content. The term "wetland" does not include:

(A) irrigated acreage used as farmland;

(B) man-made wetlands of less than one acre; or

(C) man-made wetlands not constructed with wetland creation as a stated objective, including, but not limited to, impoundments made for the purpose of soil and water conservation which have been approved or requested by soil and water conservation districts. This definition does not apply to man-made wetlands described under this subparagraph constructed or created on or after August 28, 1989. If this definition conflicts with the federal definition in any manner, the federal definition prevails.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300389
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 239-2548

♦ ♦ ♦

CHAPTER 336. RADIOACTIVE SUBSTANCE RULES

SUBCHAPTER C. GENERAL LICENSING REQUIREMENTS

30 TAC §336.227

The Texas Commission on Environmental Quality (TCEQ, agency, commission) proposes new §336.227.

Background and Summary of the Factual Basis for the Proposed Rule

The commission proposes this rule to establish an exemption from the TCEQ low-level radioactive waste (LLRW) licensing requirements for the disposal of certain radioactive tracers used in the exploration, development or production of oil and gas resources. On October 8, 2012, the executive director received a Petition for Rulemaking request from Baker Botts L.L.P., on behalf of ProTechnics Division of Core Laboratories LP. ProTechnics provides oil and gas diagnostic services to well operators to optimize reservoir performance and maximize hydrocarbon recovery from producing fields. These services include the use of radioactive tracers that are introduced into hydraulic fracturing fluids that enable well operators to take well log measurements to identify the intervals where the fluids are placed. ProTechnic's petition requested that the commission establish an exemption in rule for the disposal of the radioactive tracers used in the hydraulic fracturing operations. After considering the petition on December 5, 2012, the commission directed the executive director to initiate this rulemaking.

Occasionally, the fracking fluids and tracer material can be released back out of the well during a "sandout" and is returned to the surface. The Texas Department of State Health Services (DSHS) and the Railroad Commission of Texas (RRC) have authorized the disposal of the returned material in earthen pits at the well site or in a Class II injection well. The DSHS granted this exemption under Texas Health and Safety Code (THSC), §401.106(a) through the radioactive material license issued by DSHS to authorize the use of radioactive tracers for disposal in the earthen pits and in 25 TAC §289.253(u)(3) for disposal in a Class II injection well. Both of these exemptions have also been granted on the radioactive material licenses issued by the Nuclear Regulatory Commission (NRC). In 2007, Senate Bill 1604 of the 80th Legislature conferred TCEQ with the authority to exempt a source of radiation from the licensing requirements under the TCEQ's jurisdiction. Because the commission has jurisdiction over the disposal of radioactive substances in THSC, §401.011(b)(1), the authority to exempt radioactive substances from disposal requirements in THSC, §401.106(a) rests with the commission.

An analysis by DSHS and the NRC determined that the disposal of the radioactive tracers would not result in a significant risk to public health and safety or to the environment. The radioactive tracers have a half-life of less than 120 days and are in a form that will not leach into and migrate with the groundwater. The on-site disposal pits must be covered with at least two feet of clean soil. The commission has reviewed various pit disposal dose models, including worst-case-scenarios, that show that the total effective dose equivalent to individual members of the public from the closed pit is well below the 0.1 rem per year dose limit. Class II injection wells are permitted by the RRC after a determination that groundwater and surface water are protected from pollution. According to the petition, the disposal of radioactive tracers in earthen pits has occurred without any reported or known harm to public health and safety or the environment since May 12, 1992. The commission agrees with the determinations of both the DSHS and the NRC and finds that the proposed exemption for the on-site pit disposal and Class II injection well disposal of the tracers will not constitute a significant risk to the public health and safety and the environment.

Section Discussion

The commission proposes new §336.227 to exempt radioactive tracers from the radioactive licensing and disposal rules in Chapter 336 if the waste meets the criteria specified in §336.227(b): 1) the possession, transportation, and use of the radioactive tracers are licensed or otherwise authorized by the DSHS; 2) the tracers are in fluids that have been retrieved from a well that is used in the exploration, development, or production of oil, gas, or geothermal resources and the well is authorized by the RRC;

3) total concentration of radioactivity for all isotopes does not exceed 1,000 picocuries per gram (pCi/g), the half-life of each isotope is 120 days or less; and 4) the radioactive tracers are non-water soluble.

Section 336.227(c) would authorize the disposal of qualifying radioactive tracer material in an on-site shallow earthen pit that is permitted by the RRC for the disposal of oil and gas waste with at least two feet of clean soil, or by §336.227(d) in a Class II injection well permitted by the RRC if the permit specifically authorizes disposal of radioactive tracers.

Section 336.227(e) will require any person who disposes of radioactive tracers under this proposed rule to maintain records related to the disposal. This new rule will exempt disposal of radioactive tracer material in shallow earthen pits as provided in DSHS radioactive material licenses for the possession and use of radioactive tracers and for disposal in Class II injection wells as provided in 25 TAC §289.253(u)(3).

Fiscal Note: Costs to State and Local Government

Nina Chamness, Analyst in the Strategic Planning and Assessment Section, has determined that for the first five-year period the proposed rule is in effect, no significant fiscal implications are anticipated for the agency and no fiscal implications are anticipated for the RRC or other units of state or local government as a result of administration or enforcement of the proposed rule. The proposed rule affects licensing requirements for radioactive tracer material used in oil and gas production, development, or exploration activities. The proposed rulemaking is not expected to change current licensing or disposal standards or procedures for the agency or for the RRC and therefore is not expected to affect either agency. The only costs expected for the agency are associated with the proposal and/or adoption of the rule and are not expected to be significant.

The proposed rule would amend Chapter 336 to: exempt radioactive tracer material used in oil, gas, or geothermal exploration, development, and/or production operations from the agency's radioactive waste licensing and disposal requirements; establish the criteria for exempted radioactive tracer waste; and require record maintenance related to the disposal of such waste. The proposed rule is in response to a petition received by the agency to exempt certain radioactive tracer materials from LLRW rules as previously exempted by DSHS when the DSHS had exclusive authority to exempt a source of radiation from licensing requirements prior to June 18, 2007 and the enactment of SB 1604. Exemption of radioactive tracer materials from the agency's LLRW rules would continue to allow the petitioner to dispose of the waste per the authorization and permitting process of the RRC.

Radioactive tracer material can be disposed of by either burying the waste in shallow earthen pits with a two-foot cover or by injecting the waste into a Class II injection well (if a RRC permit specifically authorizes the disposal of radioactive tracers). Both of these disposal methods are currently in use without any reported or known harm to public health, public safety, or the environment. The NRC has also recently authorized the petitioner to dispose of these radioactive tracers using these two options. The agency agrees that RRC authorized disposal methods are safe because the radioactive tracers used in oil, gas, or geothermal exploration, development, and/or production operations have a half-life of less than 120 days and are in a form that will not leach or migrate into groundwater. Worst-case-scenarios of pit disposal methods show that the potential exposure to individuals from disposal in a closed pit is well below the 0.1 rem per year dose limit. Class II injection wells are permitted only after the RRC determines that groundwater and surface waters are protected from pollution.

Public Benefits and Costs

Nina Chamness also determined that for each year of the first five years the proposed new rule is in effect, the public benefit anticipated from the changes seen in the proposed rule will be to continue to provide an affordable method of waste disposal for oil and gas production and exploration companies who use radioactive tracers which is consistent with previous state authorized methods of disposal.

The proposed rule is not expected to have fiscal implications for individuals in general, but would affect businesses who are involved in oil, gas, or geothermal exploration, development, and/or production operations.

The proposed rule would continue to exempt radioactive tracer waste from the LLRW disposal rules and continue the practice of disposing of the waste in earthen pits or Class II injection wells as permitted by the RRC. If the proposed rulemaking is not adopted, then the radioactive tracer waste would be classified as LLRW. Waste classified as LLRW would have to be either disposed of in the Texas Compact LLRW disposal facility in Andrews County or at the LLRW disposal facility in Clive, Utah. Either of these options would result in additional costs for disposal. Disposal costs to oil and gas production or exploration companies could range from $124 to $158 per cubic foot of waste over costs for current disposal methods.

Small Business and Micro-Business Assessment

No adverse fiscal implications are anticipated for small or micro-businesses as a result of the administration or enforcement of the proposed rule. Of the 19 companies who are licensed to use radioactive tracers, 14 are thought to be small or micro-businesses. The proposed rule is not expected to result in changes to current practices or procedures and, therefore are not expected to result in any fiscal implications for these businesses. If the proposed rulemaking is not adopted, then the radioactive tracer waste would be classified as LLRW and disposal costs would increase to an estimated $124 to $158 per cubic foot of waste over costs for current disposal methods.

Small Business Regulatory Flexibility Analysis

The commission has reviewed this proposed rulemaking and determined that a small business regulatory flexibility analysis is not required because the proposed rule does not adversely affect a small or micro-business in a material way for the first five years that the proposed rule is in effect.

Local Employment Impact Statement

The commission has reviewed this proposed rulemaking and determined that a local employment impact statement is not required because the proposed rule does not adversely affect a local economy in a material way for the first five years that the proposed rule is in effect.

Draft Regulatory Impact Analysis Determination

The commission reviewed the proposed rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking is not subject to Texas Government Code, §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in the

act. "Major environmental rule" means a rule the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. The proposed new rule is not anticipated to adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state because the proposed new rule exempts from TCEQ licensing requirements disposal of certain radioactive materials, whose possession, use and transportation are authorized by the DSHS and whose disposal is authorized by the RRC as oil and gas waste. The commission proposes this rule to exempt minimal amounts of DSHS licensed radioactive tracers used in the exploration, development or production of oil and gas resources from the TCEQ low-level radioactive licensing and disposal requirements. In order to exempt these radioactive materials the commission finds that the exemption will not constitute a significant risk to the public health and safety and the environment. Radioactive tracers that are not eligible for an exemption would have to be disposed of as LLRW.

Furthermore, the proposed rulemaking does not meet any of the four applicability requirements listed in Texas Government Code, §2001.0225(a). Texas Government Code, §2001.0225 only applies to a major environmental rule, the result of which is to: 1) exceed a standard set by federal law, unless the rule is specifically required by state law; 2) exceed an express requirement of state law, unless the rule is specifically required by federal law; 3) exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopt a rule solely under the general powers of the agency instead of under a specific state law. The proposed rulemaking does not exceed a standard set by federal law, an express requirement of state law, a requirement of a delegation agreement, nor adopt a rule solely under the general powers of the agency.

THSC, Chapter 401, authorizes the commission to regulate the disposal of most radioactive material in Texas. THSC, §401.106(a) authorizes the commission to adopt rules to exempt a source of radiation from the licensing requirements of the Texas Radiation Control Act if the commission finds that the exemption of the source of radiation will not constitute a significant risk to the public health and safety and the environment. In addition, the state of Texas is an "Agreement State," authorized by the NRC to administer a radiation control program under the Atomic Energy Act. The proposed rule does not exceed a standard set by federal law. The proposed rulemaking implements an exemption that is consistent with exemptions approved by the NRC for the disposal of radioactive tracers.

The proposed rule does not exceed an express requirement of state law. THSC, Chapter 401 establishes general requirements for the licensing and disposal of radioactive materials. THSC, §401.106 specially authorizes the commission to exempt a source of radiation from the requirements to obtain a license for disposal.

The commission has also determined that the proposed rule does not exceed a requirement of a delegation agreement or contract between the state and an agency of the federal government. The State of Texas has been designated as an "Agreement State" by the NRC under the authority of the Atomic Energy Act. The Atomic Energy Act requires that the NRC find that the state radiation control program is compatible with the NRC's requirements for the regulation of radioactive materials and is adequate to protect health and safety. The commission determined that the proposed rule does not exceed the NRC's requirements nor exceed the requirements for retaining status as an "Agreement State."

The commission also determined that these rules are proposed under specific authority of THSC, Chapter 401. THSC, §§401.051, 401.103, 401.104, and 401.106 authorize the commission to adopt rules for the control of sources or radiation and the licensing and exemption of the disposal of radioactive materials.

The commission invites public comment of the draft regulatory impact analysis determination. Written comments on the draft regulatory impact analysis determination may be submitted to the contact person at the address listed under the Submittal of Comments section of this preamble.

Takings Impact Assessment

The commission evaluated the proposed rule and performed a preliminary assessment of whether the proposed rule constitutes a taking under Texas Government Code, Chapter 2007. The commission's preliminary assessment is that implementation of the proposed rule would not constitute a taking of real property. The purpose of the proposed rule is to exempt minimal amounts of DSHS-licensed radioactive tracers used in the exploration, development or production of oil and gas resources from the TCEQ low-level radioactive licensing and disposal requirements. The proposed rule would substantially advance this purpose by implementing new provisions in rule to establish the requirements for eligibility of the exemption. To qualify for the exemption, the use, possession and transportation of the radioactive material must be authorized by the DSHS and the disposal of the oil and gas waste must be authorized by the RRC. No requirements are imposed by the commission in the proposed rule that would constitute a taking of real property.

Promulgation and enforcement of the proposed rule would be neither a statutory nor a constitutional taking of private real property. The proposed rule does not affect a landowner's rights in private real property because this rulemaking does not burden (constitutionally), nor restrict or limit, the owner's right to property and reduce its value by 25% or more beyond which would otherwise exist in the absence of the rule. The proposed rule establishes an exemption from commission licensing and disposal for certain activities authorized by the DSHS and the RRC.

Consistency with the Coastal Management Program

The commission reviewed this proposed rulemaking action and determined that the proposed rule is neither identified in, nor will it affect, any action/authorization identified in Coastal Coordination Act Implementation Rules in 31 TAC §505.11, relating to Actions and Rules Subject to the Texas Coastal Management Program (CMP). Therefore, the proposed rulemaking action is not subject to the CMP.

Written comments on the consistency of this rulemaking may be submitted to the contact person at the address listed under the Submittal of Comments section of this preamble.

Announcement of Hearing

The commission will hold a public hearing on this proposal in Austin on March 5, 2013, at 10:00 a.m. in Building E, Room 201S, at the commission's central office located at 12100 Park

35 Circle. The hearing is structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. Open discussion will not be permitted during the hearing; however, commission staff members will be available to discuss the proposal 30 minutes prior to the hearing.

Persons who have special communication or other accommodation needs who are planning to attend the hearing should contact Sandy Wong, Office of Legal Services, at (512) 239-1802. Requests should be made as far in advance as possible.

Submittal of Comments

Written comments may be submitted to Bruce McAnally, MC 205, Office of Legal Services, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087, or faxed to (512) 239-4808. Electronic comments may be submitted at: *http://www5.tceq.texas.gov/rules/ecomments/*. File size restrictions may apply to comments being submitted via the eComments system. All comments should reference Rule Project Number 2013-010-336-WS. The comment period closes March 18, 2013. Copies of the proposed rulemaking can be obtained from the commission's Web site at *http://www.tceq.texas.gov/nav/rules/propose_adopt.html*. For further information, please contact Hans Weger, Radioactive Material Division, at phone (512) 239-6465.

Statutory Authority

The new rule is proposed under the Texas Radiation Control Act, Texas Health and Safety Code (THSC), Chapter 401; THSC, §401.011, which provides the commission authority to regulate and license the disposal of radioactive substances, the commercial processing and storage of radioactive substances, and the recovery and processing of source material; §401.051, which authorizes the commission to adopt rules and guidelines relating to control of sources of radiation; §401.103, which authorizes the commission to adopt rules and guidelines that provide for licensing and registration for the control of sources of radiation; §401.104, which requires the commission to provide rules for licensing for the disposal of radioactive substances; §401.106, which authorizes the commission to adopt rules to exempt a source of radiation from the licensing requirements provided by the Texas Radiation Control Act. The proposed new rule is also authorized by Texas Water Code, §5.103, which provides the commission with the authority to adopt rules necessary to carry out its powers and duties under the water code and other laws of the state.

The proposed new rule implements THSC, Chapter 401, relating to Radioactive Materials and Other Sources of Radiation, including §401.011, relating to Radiation Control Agency; §401.051, relating to Adoption of Rules and Guidelines; §401.057, relating to Records; §401.103, relating to Rules and Guidelines for Licensing and Registration; §401.104, relating to Licensing and Registration Rules; §401.106, relating to Exemption from Licensing Requirements; and §401.412, relating to Commission Licensing Authority.

§336.227. Radioactive Tracers Used in the Exploration, Development or Production of Oil or Gas or Geothermal Resources.

(a) Disposal of radioactive tracer materials used in the exploration, development or production of oil or gas or geothermal resources is exempt from licensing requirements for the disposal of radioactive substances under this chapter if the radioactive tracer materials are disposed of in accordance with this section.

(b) Radioactive tracers are eligible for exemption under this section if:

(1) the possession, transportation, and use of the radioactive tracers are licensed or otherwise authorized by the Texas Department of State Health Services;

(2) the non-water soluble radioactive tracers are in fluids that have been retrieved from a well used in the exploration, development or production of oil or gas or geothermal resources and such well is permitted or otherwise authorized by the Railroad Commission of Texas;

(3) the total concentration of radioactivity for all isotopes disposed does not exceed 1,000 picocuries per gram (pCi/g), and the half-life of each isotope is 120 days or less; and

(4) the radioactive tracers are non-water soluble.

(c) A person may dispose of radioactive tracers that are eligible for exemption under subsection (b) of this section in an on-site disposal pit that is permitted by the Railroad Commission of Texas for the disposal of oil and gas waste and is covered by at least two feet of clean soil.

(d) A person may dispose of radioactive tracers that are eligible for exemption under subsection (b) of this section in a Class II injection well permitted by the Railroad Commission of Texas for the disposal of oil and gas waste if the permit specifically authorizes the disposal of radioactive tracers.

(e) Any person who disposes of radioactive tracers exempted from licensing requirements under this section must maintain records related to the disposal, including method and location of disposal, identity of specific isotopes, estimated volume of the radioactive tracers, and total concentration of radioactivity for the isotopes disposed, and dates of disposal. The executive director may request records related to disposal of tracer materials under this section at any time.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300387
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 239-2141

♦ ♦ ♦

TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 15. ELECTRONIC TRANSFER OF CERTAIN PAYMENTS TO STATE AGENCIES

34 TAC §§15.1 - 15.18

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the

Comptroller of Public Accounts or in the Texas Register office, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

The Comptroller of Public Accounts proposes the repeal of Chapter 15, §§15.1 - 15.18, concerning the electronic transfer of certain payments to state agencies pursuant to Government Code, §404.095. The comptroller is proposing to adopt a new set of Chapter 15 rules that will update and replace the existing Chapter 15 and 16 rules. Government Code, §404.095 requires the Comptroller of Public Accounts to adopt rules specifying the approved means of electronic funds transfer and to specify the separate categories of payments. The new Chapter 15 rules do not contain any major substantive or procedural changes to the existing practice and procedures for electronic transfer of certain payments to state agencies pursuant to Government Code, §404.095. The repeal of Chapter 15 will be effective as of the date the new Chapter 15 rules take effect.

John Heleman, Chief Revenue Estimator, has determined that for the first five-year period the repeal will be in effect, there will be no significant revenue impact on the state or units of local government.

Mr. Heleman also has determined that for each year of the first five years the repeal is in effect, the public benefit anticipated as a result of enforcing the repeal will be by accommodating new rules providing improved clarity and organization. The proposed repeal would have no fiscal impact on small businesses. There is no significant anticipated economic cost to individuals who are required to comply with the proposed repeal.

Comments on the repeal of the Chapter 15 may be submitted to Tom Smelker, Director, Treasury Division, Rusk Building, 208 East 10th Street, Austin, Texas 78701-2407.

The repeal of the Chapter 15 is proposed under Government Code, §404.095, which provides the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of the Electronic Funds Transfer of Certain Payments under Government Code, §404.095.

The repeal of Chapter 15 is pursuant to Government Code, §404.095.

§15.1. Applicability

§15.2. Penalties.

§15.3. Definitions.

§15.4. Protested Tax Payments.

§15.5. State Agency Rules Requirements.

§15.6. Applicability Determination and Notification Procedures.

§15.7. Voluntary Payments by Electronic Funds Transfer.

§15.8. Payor Information.

§15.9. Means of Electronic Funds Transfer.

§15.10. Transmission of Payment Information.

§15.11. Determination of Settlement Day.

§15.12. Transfer of Funds to the Treasury.

§15.13. Backup Procedures.

§15.14. Late Payments.

§15.15. Proof of Payment.

§15.16. Refunds.

§15.17. Effective Date.

§15.18. Notification.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 29, 2013.

TRD-201300321
Ashley Harden
General Counsel
Comptroller of Public Accounts
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 475-0387

♦ ♦ ♦

CHAPTER 15. ELECTRONIC TRANSFER OF PAYMENTS TO STATE AGENCIES

SUBCHAPTER A. APPLICABILITY, DEFINITIONS AND PAYMENT CATEGORIES

34 TAC §§15.1 - 15.8

The Comptroller of Public Accounts proposes new Chapter 15, Subchapter A, §§15.1 - 15.8, concerning Applicability, Definitions and Payment Categories pursuant to Government Code, §404.095. The comptroller is proposing to adopt new Chapter 15 rules, including new Subchapters A - D, to update and replace the existing Chapter 15 and 16 rules. Government Code, §404.095 requires the Comptroller of Public Accounts to adopt rules specifying the approved means of electronic funds transfer and to specify the separate categories of payments. The new Chapter 15 rules do not contain any major substantive or procedural changes to the existing practice and procedures for electronic transfer of certain payments to state agencies pursuant to Government Code, §404.095. The Comptroller of Public Accounts will repeal the existing Chapter 15 and 16 rules as of the date the new Chapter 15 rules take effect.

The rules in Chapter 15, Subchapter A, address the applicability, definitions, and payment categories for the electronic transfer of certain payments to state agencies under Government Code, §404.095. Section 15.1, Applicability and Additional Information, explains the applicability to electronically transfer certain payments to a state agency by an approved means of electronic funds transfer under Government Code, §404.095, and how to find additional information on the subject. Section 15.2, Approved Means of Electronic Funds Transfer, sets out the approved means of electronic funds transfer under Government Code, §404.095. Section 15.3, Definitions, contains the definitions for the Chapter 15 rules. Section 15.4, Applicable Payment Categories and Voluntary Payments, discusses the applicable payment categories and voluntary payments. Section 15.5, Payment Category: Fees, discusses the payment category of fees and §15.6, Payment Category: Taxes, relates to the payment category of taxes. Section 15.7, Payment Category: Other Payments, relates to the payment category of other payments. Section 15.8, Voluntary Payments by Electronic Funds Transfer, discusses voluntary payments by electronic funds transfer.

John Heleman, Chief Revenue Estimator, has determined that for the first five-year period the rules will be in effect, there will

be no significant revenue impact on the state or units of local government.

Mr. Heleman also has determined that for each year of the first five years the rules are in effect, the public benefit anticipated as a result of enforcing the rules will be improving the rules' clarity and organization with regard to the electronic transfer of certain payments to state agencies. The proposed new rules would have no fiscal impact on small businesses. There is no significant anticipated economic cost to individuals who are required to comply with the proposed rules.

Comments on proposed new Chapter 15, Subchapter A may be submitted to Tom Smelker, Director, Treasury Division, Rusk Building, 208 East 10th Street, Austin, Texas 78701-2407.

The new Chapter 15, Subchapter A is proposed under Government Code, §404.095, which provides the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of the Electronic Funds Transfer of Certain Payments under Government Code, §404.095.

The proposal of new Chapter 15, Subchapter A is pursuant to Government Code, §404.095.

§15.1. Applicability and Additional Information.

(a) Any and all payments subject to Government Code, §404.095, must be made in accordance with this chapter.

(b) Pursuant to Government Code, §404.095, a person must electronically transfer certain payments to a state agency by one of the means of EFT approved by the comptroller if the following apply:

(1) the payment is to a state agency that collected or received more than $50 million in payments during the preceding state fiscal year in fees, fines, penalties, taxes, charges, gifts, grants, donations, and other funds, excluding federal grants and interest and dividend income; and

(2) the person paid the state agency a total of $500,000 or more in the preceding state fiscal year in a category of payment listed in §15.4 of this title (relating to Applicable Payment Categories and Voluntary Payments), and the state agency reasonably anticipates that during the current state fiscal year the person will pay the agency $500,000 or more in the same category of payment.

(c) The state agencies that typically collect or receive more than $50 million in payments in a state fiscal year are:

(1) Comptroller of Public Accounts;

(2) Employees Retirement System;

(3) General Land Office;

(4) Teacher Retirement System;

(5) Texas Alcoholic Beverage Commission;

(6) Health and Human Services Commission;

(7) Texas Department of Motor Vehicles;

(8) Texas Department of Public Safety;

(9) Texas Department of Transportation;

(10) Texas Workforce Commission;

(11) Texas Commission on Environmental Quality;

(12) Texas Parks and Wildlife Department; and

(13) University of Texas System.

(d) Pursuant to Government Code, §404.095, a state agency may adopt rules under this chapter that require a person to make payments by EFT using TexNet. The rules under this chapter also apply to all persons who are subject to such adopted state agency rules.

(e) For additional information regarding the EFT of certain payments to state agencies under Government Code, §404.095, consult the comptroller's website at http://www.window.state.tx.us/treasops/texnet/.

§15.2. Approved Means of Electronic Funds Transfer.

(a) Pursuant to Government Code, §404.095(e), the comptroller must adopt rules specifying the approved means of EFT for the payments required under Government Code, §404.095.

(b) A person must use TexNet, the State of Texas Financial Network, to make an EFT payment required under Government Code, §404.095. A person may choose any of the following TexNet payment options as an approved means of EFT:

(1) ACH debit/direct entry;

(2) ACH debit/indirect entry; or

(3) ACH credit with addenda record(s) in CCD+ or CTX format.

(c) Wire transfer is not an approved means of making payment by EFT under Government Code, §404.095. However, wire transfer may be used in limited circumstances as permitted by §15.41 of this title (relating to Missed Payment Deadline Procedures).

§15.3. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Access code--A unique and confidential series of numbers assigned to a person by TexNet that allows the person to communicate payment information to the TexNet data collection system.

(2) ACH (Automated Clearing House)--A central distribution and settlement point for the electronic clearing of debits and credits between financial institutions subject to regulation under rules of an automated clearinghouse association and applicable regulatory law.

(3) ACH credit with addenda record(s)--An ACH transaction in CCD+ or CTX format which is initiated by the person to make an EFT payment.

(4) ACH debit/direct entry--An ACH transaction initiated by the comptroller using payment information entered directly into the TexNet data collection system by the person to make an EFT payment.

(5) ACH debit/indirect entry--An ACH transaction to make an EFT payment that is initiated by the comptroller, which is based upon payment information entered into the TexNet payment processing system by the person's state agency in a specified manner approved by the comptroller.

(6) ACH transaction--An electronic transaction which is cleared through the ACH.

(7) Addenda record--A separate record transmitted with an ACH credit which contains payment information in the approved State of Texas addenda record format.

(8) Banking holiday--Any holiday observed by the Federal Reserve Bank of Dallas and its member institutions.

(9) Business day--Any day when financial transactions are processed through the banking system; normally not a Saturday, Sunday, or a banking holiday.

(10) Categories of payments--Those types of payments to a state agency that may trigger a requirement to transfer payment electronically under Government Code, §404.095, as set out in §15.4 of this title (relating to Applicable Payment Categories and Voluntary Payments).

(11) CCD+ format (cash concentration or disbursement with one addenda record)--A standard ACH transaction format which includes one addenda record.

(12) Comptroller--The Comptroller of Public Accounts and its successors.

(13) Comptroller's bank--A financial institution, which is a member of the Federal Reserve System, that the comptroller has contracted with to originate ACH debits or receive ACH credits.

(14) CTX format (corporate trade exchange format)--A standard ACH transaction format which includes up to 9,999 addenda records.

(15) Due date--Date on which a payment to a state agency by a person is due. If the due date is a Saturday, Sunday, or a banking holiday, the next business day shall be the due date.

(16) Electronic Funds Transfer (EFT)--A transfer of funds, other than a transaction originated by check, draft, warrant or similar paper instrument, which is initiated through an electronic terminal, or computer so as to order, instruct, or authorize a financial institution to debit or credit an account in accordance with this chapter.

(17) Payment information--The specific information required by the state agency from a person making an EFT payment to ensure accurate credit of the payment.

(18) Payor identification number--A unique number assigned by a state agency to a person who makes payments to that state agency.

(19) Person--A payor, including, but not limited to an individual, corporation, partnership, association, legal representative, trustee in bankruptcy, receiver, municipality, county, district, or political subdivision, who makes payments to a state agency in any of the separate categories of payments listed in Government Code, §404.095.

(20) Person's bank--The financial institution at which the person maintains an account from which electronic transactions will occur.

(21) Recurring surcharges--A recurring surcharge that is considered a separate category of payment under the category of other payments to a state agency, as set out in §15.4 of this title.

(22) Settlement date--The business day on which funds are electronically transferred from the person's bank account to the appropriate account at the comptroller's bank.

(23) State agency--Any agency of the state that during the preceding state fiscal year collected or received more than $50 million in fees, fines, penalties, taxes, charges, gifts, grants, donations, and other funds, excluding federal grants and interest and dividend income. A list of state agencies that typically collect or receive more than $50 million in a state fiscal year is set out in §15.1 of this title (relating to Applicability and Additional Information).

(24) State fiscal year--The twelve month period beginning on September 1 of each year and ending on August 31 of the following calendar year.

(25) TexNet--The State of Texas Financial Network. TexNet is the exclusive system designed and maintained by the comptroller to facilitate and process the electronic transfer of funds from a person making certain EFT payments to a state agency under Government Code, §404.095.

(26) TexNet data collection system--The system designed and maintained by the comptroller to collect payment data to initiate an EFT payment under Government Code, §404.095.

(27) TexNet payment processing system--The system designed and maintained by the comptroller to process payment data to facilitate the electronic transfer of funds and related information.

(28) Trace number--A number provided to a person by the TexNet data collection system upon receipt of all payment information that uniquely identifies the completed communication.

(29) Wire transfer--An unconditional order to a bank to pay a fixed or determinable amount of money to a beneficiary upon receipt or on a day stated in the order that is transmitted by electronic means. Wire transfer is not an approved means of electronic fund transfer as set out in §15.2 of this title (relating to Approved Means of Electronic Funds Transfer), but may be used as permitted by §15.41 of this title (relating to Missed Payment Deadline Procedures).

§15.4. Applicable Payment Categories and Voluntary Payments.

(a) Each of the following is a separate category of payments to a state agency:

(1) fees, with each type of fee listed in §15.5 of this title (relating to Payment Category: Fees) considered a separate category of payment;

(2) fines;

(3) civil penalties;

(4) taxes, with each type of tax listed in §15.6 of this title (relating to Payment Category: Taxes) being considered a separate category; and

(5) other payments to a state agency excluding extraordinary payments such as gifts, grants, donations, interest, and dividend income, and one-time surcharges; and listed in §15.7 of this title (relating to Payment Category: Other Payments).

(b) A person making payments to a state agency in a particular category of payment who is not required to electronically transfer payments may do so voluntarily, as described in §15.8 of this title (relating to Voluntary Payments by Electronic Funds Transfer).

(c) For additional information regarding payment categories and voluntary payments under Government Code, §404.095, consult the state agency and the comptroller's website at http://www.window.state.tx.us/treasops/texnet/.

§15.5. Payment Category: Fees.

For purposes of making payments to a state agency by EFT under Government Code, §404.095, and this chapter, each of the following fees shall be considered a separate category of payment. Subject to amendment, the categories of fees include, but are not limited to:

(1) automotive oil sales fees;

(2) battery sales fees;

(3) civil fees;

(4) coastal protection fees;

(5) criminal cost and fees;

(6) driver record fees;

(7) drug court program fees;

(8) hunting and fishing license fees;

(9) motor vehicle title application fees;

(10) petroleum products delivery fees;

(11) photo enforcement fees;

(12) registration fees;

(13) sexual assault/substance abuse fees;

(14) sexual oriented business fees;

(15) title application fees;

(16) 911 emergency service fees;

(17) 911 prepaid wireless emergency service fees; and

(18) 911 wireless service fees.

§15.6. Payment Category: Taxes.

(a) For purposes of making payments to a state agency by EFT under Government Code, §404.095 and this chapter, each of the following taxes shall be considered a separate category of payment. Subject to amendment, the categories of taxes include, but are not limited to:

(1) automobile theft prevention authority assessment tax;

(2) bank tax;

(3) beer reporting system tax;

(4) Bexar county sports venue project tax;

(5) boat and boat motor sales tax;

(6) cement production tax;

(7) cigarette tax;

(8) crude oil production tax;

(9) diesel fuel tax;

(10) direct pay sales tax;

(11) Euless city sports venue tax;

(12) fireworks sales tax;

(13) franchise tax;

(14) gasoline tax;

(15) gross receipts tax;

(16) hotel occupancy tax;

(17) insurance maintenance, assessment, and retaliatory tax;

(18) insurance premium tax;

(19) interest earned on sales tax;

(20) international fuel tax agreement (IFTA);

(21) interstate trucker fuel tax--diesel/gasoline/liquefied gas;

(22) liquefied gas tax;

(23) liquor reporting system tax;

(24) malt liquor reporting system tax;

(25) manufactured housing sales and use tax;

(26) mixed beverage gross receipts tax;

(27) motor vehicle rental tax;

(28) motor vehicle sales tax;

(29) natural gas production tax;

(30) oil and gas well servicing tax;

(31) public utilities gross receipts assessment tax;

(32) sales and use tax;

(33) seller financed motor vehicle sales tax;

(34) sports venue tax;

(35) sulphur tax;

(36) tobacco products tax;

(37) unemployment compensation tax; and

(38) volunteer fire department insurance tax.

(b) A state agency may not require a person to electronically transfer a protested tax payment. However, a person may voluntarily submit a protested tax payment by EFT. For more information on voluntary protest tax payments consult §3.9 of this title (relating to Electronic Filing of Returns and Reports; Electronic Transfer of Certain Payments by Certain Taxpayers).

(c) For more information regarding the procedures to pay taxes by EFT, consult the applicable state agency, §3.9 of this title, and the comptroller's website http://www.window.state.tx.us/treasops/texnet/.

§15.7. Payment Category: Other Payments.

(a) For purposes of making payments to a state agency by EFT under Government Code, §404.095 and this chapter, other payments to a state agency include assessments and recurring surcharges, as listed in this section.

(b) Assessments shall be considered a separate category of payment.

(c) Each of the following recurring surcharges shall be considered a separate category of payment. Subject to amendment, the categories of surcharges include, but are not limited to:

(1) motor vehicle registration surcharge;

(2) motor vehicle sales surcharge;

(3) off-road diesel equipment surcharge;

(4) motor vehicle seller financed sales tax surcharge; and

(5) 911 equalization surcharge.

(d) Other payments to a state agency do not include extraordinary payments such as gifts, grants, donations, interest and dividend income, and one-time surcharges. Subject to amendment, other payments include, but are not limited to:

(1) oil royalties;

(2) gas royalties;

(3) Employee Retirement System contributions;

(4) Teacher Retirement System contributions;

(5) unclaimed property; and

(6) intergovernmental transfers.

§15.8. Voluntary Payments by Electronic Funds Transfer.

(a) A person who is not required to electronically transfer a particular category of payments to a state agency may do so voluntarily. A person who makes voluntary EFT payments is responsible for:

(1) contacting the state agency to which payments are due to obtain the information set out in §15.22(b) of this title (relating

to State Agency Applicability Determination and Notification Procedures);

(2) enrolling in TexNet as described in §15.31 of this title (relating to TexNet Enrollment); and

(3) transferring payments as provided in §15.32 of this title (relating to Transmission of TexNet Payment Information).

(b) A person who was previously required to make EFT payments to a state agency who no longer meets the applicable payment threshold may continue to make EFT payments as a voluntary payor without notification to the state agency.

(c) A person shall notify the state agency if the person elects to discontinue making voluntary EFT payments.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 29, 2013.

TRD-201300323
Ashley Harden
General Counsel
Comptroller of Public Accounts
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 475-0387

♦ ♦ ♦

SUBCHAPTER B. STATE AGENCY PRACTICE AND PROCEDURES

34 TAC §15.21, §15.22

The Comptroller of Public Accounts proposes new Chapter 15, Subchapter B, §15.21 and §15.22, concerning State Agency Practice and Procedures, pursuant to Government Code, §404.095. The comptroller is proposing to adopt new Chapter 15 rules, including new Subchapters A - D, to update and replace the existing Chapter 15 and 16 rules. Government Code, §404.095 requires the Comptroller of Public Accounts to adopt rules specifying the approved means of electronic funds transfer and to specify the separate categories of payments. The new Chapter 15 rules do not contain any major substantive or procedural changes to the existing practice and procedures for electronic transfer of certain payments to state agencies pursuant to Government Code, §404.095. The Comptroller of Public Accounts will repeal the existing Chapter 15 and 16 rules as of the date the new Chapter 15 rules take effect.

The rules in Chapter 15, Subchapter B address the state agency practice and procedures for the electronic transfer of certain payments to state agencies under Government Code, §404.095. Section 15.21, State Agency Rules Requirements, concerns state agencies that have adopted rules to require payment by electronic funds transfer under Government Code, §404.095(c). Section 15.22, State Agency Applicability Determination and Notification Procedures, relates to a state agency's requirements to determine which persons are required to make payment to that agency by electronic funds transfer and to notify the affected persons.

John Heleman, Chief Revenue Estimator, has determined that for the first five-year period the rules will be in effect, there will be no significant revenue impact on the state or units of local government.

Mr. Heleman also has determined that for each year of the first five years the rules are in effect, the public benefit anticipated as a result of enforcing the rules will be improving the rules' clarity and organization with regard to the electronic transfer of certain payments to state agencies. The proposed new rules would have no fiscal impact on small businesses. There is no significant anticipated economic cost to individuals who are required to comply with the proposed rules.

Comments on proposed new Chapter 15, Subchapter B may be submitted to Tom Smelker, Director, Treasury Division, Rusk Building, 208 East 10th Street, Austin, Texas 78701-2407.

The new Chapter 15, Subchapter B is proposed under Government Code, §404.095, which provides the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of the Electronic Funds Transfer of Certain Payments under Government Code, §404.095.

The proposal of new Chapter 15, Subchapter B is pursuant to Government Code, §404.095.

§15.21. State Agency Rules Requirements.

(a) A state agency which has adopted rules requiring EFT payments pursuant to Government Code, §404.095(c) and §15.1(d) of this title (relating to Applicability and Additional Information) shall notify each person to whom the rules apply. The notice shall include the information set out in §15.22(b) of this title (relating to State Agency Applicability Determination and Notification Procedures) and shall be provided at least 60 days before the first payment is due, but not later than November 1 of each year.

(b) All persons to whom state agency rules apply shall be required to electronically transfer payments to the state agency beginning on the date set forth in the notification and thereafter until said person is no longer subject to the state agency's rules.

(c) A state agency may not require a person to electronically transfer a protested tax payment, however, a person may choose to pay such payments voluntarily as set out in §15.8 of this title (relating to Voluntary Payments by Electronic Funds Transfer).

(d) For additional information on state agency rules and payment instructions, consult the state agency in question and the comptroller's website at: http://www.window.state.tx.us/treasops/texnet/.

§15.22. State Agency Applicability Determination and Notification Procedures.

(a) By October 15 of each year, each state agency shall determine which persons are required to make EFT payments to the state agency.

(b) By November 1 of each year, each state agency shall notify and send the following information to all persons who are required to make EFT payments, except as provided by subsection (c) of this section:

(1) guidelines on payment transfers;

(2) guidelines on enrollment in TexNet;

(3) the contact information for the personnel at the state agency with whom a person may communicate in the event of questions or problems; and

(4) such other information the state agency or the comptroller deems necessary.

(c) State agencies shall not be required to notify persons who are currently making EFT payments, nor shall state agencies be required to notify persons who are no longer required to make EFT payments. Persons who are no longer required to make EFT payments shall be considered voluntary payors as set out in §15.8 of this title (relating to Voluntary Payments by Electronic Funds Transfer).

(d) Following the determination and notification dates listed in subsections (a) and (b) of this section, all persons required to make EFT payments to a state agency shall do so for the period of one year, beginning January 1 and ending December 31, and each year thereafter until the person no longer meets the payment thresholds set out in §15.1 of this title (relating to Applicability and Additional Information) and does not wish to participate as a voluntary payor as set out in §15.8 of this title.

(e) A person may contact the state agency to which payments are due for a determination of whether the person is required to make EFT payments at any time.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 29, 2013.

TRD-201300324
Ashley Harden
General Counsel
Comptroller of Public Accounts
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 475-0387

♦ ♦ ♦

SUBCHAPTER C. TEXNET: GENERAL PAYMENT PROCEDURES

34 TAC §§15.31 - 15.35

The Comptroller of Public Accounts proposes new Chapter 15, Subchapter C, §§15.31 - 15.35, concerning TexNet: General Payment Procedures pursuant to Government Code, §404.095. The comptroller is proposing to adopt new Chapter 15 rules, including new Subchapters A - D, to update and replace the existing Chapter 15 and 16 rules. Government Code, §404.095 requires the Comptroller of Public Accounts to adopt rules specifying the approved means of electronic funds transfer and to specify the separate categories of payments. The new Chapter 15 rules do not contain any major substantive or procedural changes to the existing practice and procedures for electronic transfer of certain payments to state agencies pursuant to Government Code, §404.095. The Comptroller of Public Accounts will repeal the existing Chapter 15 and 16 rules as of the date the new Chapter 15 rules take effect.

The rules in Chapter 15, Subchapter C address the general payment procedures for the electronic transfer of certain payments to state agencies using TexNet, the State of Texas Financial Network, to facilitate and process the electronic transfer of funds under Government Code, §404.095. Section 15.31, TexNet Enrollment, concerns the TexNet enrollment process. Section 15.32, Transmission of TexNet Payment Information, relates to the transmission of TexNet payment information. Section 15.33, Determination of Settlement Date, discusses the determination of settlement date and §15.34, Transfer of Funds to the Comptroller, relates to the transfer of funds to the comptroller. Section 15.35, Notification to Comptroller, provides information on how to provide notification to the comptroller.

John Heleman, Chief Revenue Estimator, has determined that for the first five-year period the rules will be in effect, there will be no significant revenue impact on the state or units of local government.

Mr. Heleman also has determined that for each year of the first five years the rules are in effect, the public benefit anticipated as a result of enforcing the rules will be improving the rules' clarity and organization with regard to the electronic transfer of certain payments to state agencies. The proposed new rules would have no fiscal impact on small businesses. There is no significant anticipated economic cost to individuals who are required to comply with the proposed rules.

Comments on proposed new Chapter 15, Subchapter C may be submitted to Tom Smelker, Director, Treasury Division, Rusk Building, 208 East 10th Street, Austin, Texas 78701-2407.

The new Chapter 15, Subchapter C is proposed under Government Code, §404.095, which provides the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of the Electronic Funds Transfer of Certain Payments under Government Code, §404.095.

The proposal of new Chapter 15, Subchapter C is pursuant to Government Code, §404.095.

§15.31. TexNet Enrollment.

(a) The person must complete TexNet enrollment according to the guidelines provided (see §15.22(b) of this title (relating to State Agency Applicability Determination and Notification Procedures)). Upon completion of the TexNet enrollment, and based upon the person's chosen TexNet payment option, the person will be provided with:

(1) the access code and instructions for entering payment information into the TexNet data collection system by the chosen method of entry described in §15.32(b) of this title (relating to Transmission of TexNet Payment Information) if the person has chosen ACH debit/direct entry;

(2) the instructions for entering payment information in the manner established by the person's state agency and approved by the comptroller if the person has chosen ACH debit/indirect entry; or

(3) the routing and account number to which the person shall transfer payment and the approved State of Texas addenda record format if the person has chosen ACH credit with addenda record(s).

(b) A person must notify the comptroller (see §15.35 of this title (relating to Notification to the Comptroller)) of any change of information from that given during the TexNet enrollment process or thereafter.

(1) A change in the person's bank routing number or account number, or a change to or from the ACH debit/direct entry means of EFT, may be communicated to the comptroller in writing, entered into the TexNet data collection system by the person, or entered into the TexNet payment processing system by the person's state agency in the manner established by the state agency and approved by the comptroller. The change will be effective upon acceptance, unless the change is communicated in writing. If communicated in writing, the change will be effective upon notification to the person by the comptroller of acceptance of the change.

(2) A person may communicate any other changes of information from that given in the TexNet enrollment process to the comptroller in writing, by telephone, or by entering it into the TexNet data collection system. Changes are effective immediately, unless the communication is in writing. A written change is effective when the person receives the comptroller's notification of acceptance of the change.

§15.32. Transmission of TexNet Payment Information.

(a) A person must transmit accurate payment information to ensure proper credit of the payment to the state agency receiving payment.

(b) A person's chosen TexNet payment option for EFT (see §15.2(b) of this title (relating to Approved Means of Electronic Funds Transfer)) will determine the method of transmitting payment information.

(1) Persons choosing ACH debit/direct entry as the TexNet payment option for EFT shall:

(A) enter payment information directly into the TexNet data collection system using either the Internet or a touch-tone telephone no later than 6:00 p.m. central time on the business day before the due date;

(B) record the trace number provided by the TexNet data collection system once all payment information has been entered by the person;

(C) enter any change, correction, or cancellation in the payment information to the TexNet data collection system no later than 6:00 p.m. central time on the business day before the settlement date; and

(D) contact the comptroller at the telephone number listed in §15.35 of this title (relating to Notification to the Comptroller) if the person experiences difficulty entering information into the TexNet data collection system.

(2) Persons choosing ACH debit/indirect entry as the TexNet payment option for EFT shall enter payment information in the manner and by the deadline established by the state agency to which payment is due and approved by the comptroller.

(3) Persons choosing ACH credit with addenda record(s) as the TexNet payment option for EFT shall transmit payment information in the addenda record(s) of the ACH credit in the approved State of Texas addenda record format, as set out in the TexNet instruction booklet for the state agency, which is posted at http://www.window.state.tx.us/treasops/texnet/. A person who does not have access to the Internet may consult with the state agency for further information and TexNet payment instructions.

§15.33. Determination of Settlement Date.

(a) Persons choosing ACH debit/direct entry as the TexNet payment option for EFT may either accept the settlement date offered by the TexNet data collection system or enter a settlement date up to 30 days in the future.

(1) If the person accepts the settlement date offered by the TexNet data collection system, it will always be the business day following the day payment information is entered into the TexNet data collection system, provided that the person enters the information by 6:00 p.m. central time on a business day.

(2) If the person chooses to enter a settlement date up to 30 days in the future, the person's bank account will be debited on the designated settlement date.

(b) For persons choosing ACH debit/indirect entry as the TexNet payment option for EFT, the settlement date will always be the business day following the day payment information is entered into the TexNet payment processing system, provided that the person enters the information by 6:00 p.m. central time on a business day.

(c) Persons choosing ACH credit with addenda as the TexNet payment option for EFT transfer must initiate payment through the person's bank before the settlement date and the funds must be in the comptroller's bank on the settlement date.

(d) A person who misses a payment deadline may use wire transfer to transmit the payment as set out in §15.41 of this title (relating to Missed Payment Deadline Procedures).

§15.34. Transfer of Funds to the Comptroller.

Transfer of funds to the comptroller shall occur as follows:

(1) For persons choosing ACH debit/direct entry as the TexNet payment option for EFT, the payment amount entered into the TexNet data collection system by the person will be automatically withdrawn from the person's bank account on the designated settlement date as set out in §15.33 of this title (relating to Determination of Settlement Date), and no further action is required.

(2) For persons choosing ACH debit/indirect entry as the TexNet payment option for EFT, the payment amount entered into the TexNet payment processing system by the state agency to which payment is due will be automatically withdrawn from the person's bank account on the settlement date and no further action is required.

(3) Persons choosing ACH credit with addenda record(s) as the TexNet payment option for EFT must send the ACH credit to the comptroller for settlement on or before the due date. The addenda record(s) must be transmitted in the approved State of Texas addenda record format(s).

§15.35. Notification to the Comptroller.

Any notification to the comptroller regarding EFT payments by mail, telephone, or fax must be directed to: Comptroller of Public Accounts, Treasury Operations, P.O. Box 12608, Austin, Texas 78711, phone number (800) 531-5441, extension 3-3010 and fax (512) 463-1364.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 29, 2013.

TRD-201300325
Ashley Harden
General Counsel
Comptroller of Public Accounts
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 475-0387

♦ ♦ ♦

SUBCHAPTER D. TEXNET: SPECIAL PAYMENT PROCEDURES

34 TAC §§15.41 - 15.45

The Comptroller of Public Accounts proposes new Chapter 15, Subchapter D, §§15.41 - 15.45, concerning TexNet: Special Payment Procedures pursuant to Government Code, §404.095. The comptroller is proposing to adopt new Chapter 15 rules, including new Subchapters A - D, to update and replace the existing Chapter 15 and 16 rules. Government Code, §404.095

requires the Comptroller of Public Accounts to adopt rules specifying the approved means of electronic funds transfer and to specify the separate categories of payments. The new Chapter 15 rules do not contain any major substantive or procedural changes to the existing practice and procedures for electronic transfer of certain payments to state agencies pursuant to Government Code, §404.095. The Comptroller of Public Accounts will repeal the existing Chapter 15 and 16 rules as of the date the new Chapter 15 rules take effect.

The rules in Chapter 15, Subchapter D address special payment procedures for the electronic transfer of certain payments to state agencies under TexNet, the State of Texas Financial Network used to facilitate and process the electronic transfer of funds under Government Code, §404.095. Section 15.41, Missed Payment Deadline Procedures, sets out the procedures for missed payment deadlines. Section 15.42, Late Payment, concerns late payments. Section 15.43, Penalties, relates to penalties for failure to make payments by electronic funds transfer or to comply with the comptroller's rules for the electronic payment to certain agencies. Section 15.44, Proof of Payment, concerns the proof of payment to document a person's attempt to timely transfer payment by electronic funds transfer. Section 15.45, Refunds, relates to refunds of payments made by electronic funds transfer under Government Code, §404.095.

John Heleman, Chief Revenue Estimator, has determined that for the first five-year period the rules will be in effect, there will be no significant revenue impact on the state or units of local government.

Mr. Heleman also has determined that for each year of the first five years the rules are in effect, the public benefit anticipated as a result of enforcing the rules will be improving the rules' clarity and organization with regard to the electronic transfer of certain payments to state agencies. The proposed new rules would have no fiscal impact on small businesses. There is no significant anticipated economic cost to individuals who are required to comply with the proposed rules.

Comments on the proposed new Chapter 15, Subchapter D may be submitted to Tom Smelker, Director, Treasury Division, Rusk Building, 208 East 10th Street, Austin, Texas 78701-2407.

The new Chapter 15, Subchapter D is proposed under Government Code, §404.095, which provides the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of the Electronic Funds Transfer of Certain Payments under Government Code, §404.095.

The proposal of new Chapter 15, Subchapter D is pursuant to Government Code, §404.095.

§15.41. Missed Payment Deadline Procedures.

(a) A person must use the procedures set out in subsections (b) and (c) of this section to ensure timely credit of a payment if a person is making an EFT payment using:

(1) ACH debit/direct entry and is unable to enter payment information into the TexNet data collection system by 6:00 p.m. central time on the business day before the due date;

(2) ACH debit/indirect entry and is unable to enter payment information by the deadline specified to transfer the payment information to the TexNet payment processing system; or

(3) ACH credit with addenda record(s) and is unable to affect such transfer for credit to the comptroller on the due date.

(b) If one of the conditions under subsection (a) of this section applies, then the person must wire transfer the payment to the comptroller by noon central time on the due date, and include the payor identification number and a contact name and telephone number in the wire transfer.

(c) The person must also communicate payment information to the comptroller by noon central time on the due date using one of the following means:

(1) report the payment information to a comptroller employee by calling the toll-free number listed in §15.35 of this title (relating to Notification to the Comptroller); or

(2) enter payment information directly into the TexNet data collection system, if the system accepts wire transfer information for the person's type of payment.

§15.42. Late Payment.

(a) To ensure credit of the payment to the proper state agency and to the correct category of payment, a person must provide correct and timely payment information as described in §15.32 of this title (relating to Transmission of TexNet Payment Information).

(b) The state agency to which the payment is due shall make any late payment determination if:

(1) the payment is not credited to the proper state agency or to the correct category of payment due to insufficient or incomplete payment information; or

(2) as a result of circumstances within the control of the person or the person's bank, the transfer of payment to the appropriate comptroller account fails and the payment is received after the due date.

§15.43. Penalties.

(a) A state agency may assess a penalty of 5.0% of the payment amount due if:

(1) a person subject to Government Code, §404.095 and §15.1(a) of this title (relating to Applicability and Additional Information) fails to transfer payment by EFT;

(2) a person fails to comply with this chapter; or

(3) a person fails to comply with those rules adopted by a state agency under Government Code, §404.095(c).

(b) The comptroller will assist state agencies in identifying persons who are not complying with this chapter.

§15.44. Proof of Payment.

(a) If a person follows the procedures set out to electronically transfer payment to a state agency, but the payment is not received by the comptroller, a person must produce proof of an attempt to timely transfer payment within 30 days following the attempted payment.

(b) A person may rely upon the following information as proof of an attempt to timely transfer payment:

(1) the trace number provided by the TexNet data collection system if ACH debit/direct entry is the chosen TexNet payment option for EFT;

(2) the trace number provided by the person's state agency if ACH debit/indirect entry is the chosen TexNet payment option for EFT;

(3) the trace number assigned by the person's bank if ACH credit with addenda record(s) is the chosen TexNet payment option for EFT; or

(4) the Federal Reserve Bank reference number if wire transfer is used as permitted under §15.41 of this title (relating to Missed Payment Deadline Procedures).

(c) Upon a determination by the comptroller that the person and the person's bank did timely and correctly attempt to transfer payment, the state agency will correct the applicable payment records upon receipt of the funds from the person.

§15.45. Refunds.

If a state agency determines that a person has mistakenly made a payment or overpayment by EFT, the state agency shall return the payment or the amount of the overpayment to the person in the manner established by the state agency.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 29, 2013.

TRD-201300326
Ashley Harden
General Counsel
Comptroller of Public Accounts
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 475-0387

♦ ♦ ♦

CHAPTER 16. ELECTRONIC TRANSFER OF PAYMENTS TO THE TEXAS STATE TREASURY DEPARTMENT

34 TAC §16.1, §16.2

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Comptroller of Public Accounts or in the Texas Register office, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

The Comptroller of Public Accounts proposes the repeal of Chapter 16, §16.1 and §16.2, concerning electronic transfer of payments to the former Texas State Treasury Department pursuant to Government Code, §404.095. The comptroller is proposing to adopt a new set of Chapter 15 rules that will update and replace the existing Chapter 15 and 16 rules. Government Code, §404.095 requires the Comptroller of Public Accounts to adopt rules specifying the approved means of electronic funds transfer and to specify the separate categories of payments. The new Chapter 15 rules do not contain any major substantive or procedural changes to the existing practice and procedures for electronic transfer of certain payments to state agencies pursuant to Government Code, §404.095. The repeal of Chapter 16 will be effective as of the date the new Chapter 15 rules take effect.

John Heleman, Chief Revenue Estimator, has determined that for the first five-year period the repeal will be in effect, there will be no significant revenue impact on the state or units of local government.

Mr. Heleman also has determined that for each year of the first five years the repeal is in effect, the public benefit anticipated as a result of enforcing the repeal will be by accommodating new rules providing improved clarity and organization. The proposed repeal would have no fiscal impact on small businesses. There is no significant anticipated economic cost to individuals who are required to comply with the proposed repeal.

Comments on the repeal of Chapter 16 may be submitted to Tom Smelker, Director, Treasury Division, Rusk Building, 208 East 10th Street, Austin, Texas 78701-2407.

The repeal of Chapter 16 is proposed under Government Code, §404.095, which provides the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of the Electronic Funds Transfer of Certain Payments under Government Code, §404.095.

The repeal of Chapter 16 is pursuant to Government Code, §404.095.

§16.1. Adoption by Reference.

§16.2. Applicability.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 29, 2013.

TRD-201300322
Ashley Harden
General Counsel
Comptroller of Public Accounts
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 475-0387

♦ ♦ ♦

TITLE 43. TRANSPORTATION

PART 1. TEXAS DEPARTMENT OF TRANSPORTATION

CHAPTER 1. MANAGEMENT

SUBCHAPTER F. ADVISORY COMMITTEES

43 TAC §1.85

The Texas Department of Transportation (department) proposes amendments to §1.85, concerning department advisory committees.

EXPLANATION OF PROPOSED AMENDMENTS

The proposed amendment creates a freight advisory committee that provides advice and recommendations to the department regarding freight transportation matters and assists in identifying potential freight transportation facilities. The purpose of the proposed amendment is to implement §1117 of Moving Ahead for Progress in the 21st Century, which directs the United States Secretary of Transportation to encourage state departments of transportation to establish freight advisory committees to facilitate effective planning for freight transportation.

New §1.85(a)(5) creates the Freight Advisory Committee.

Section 1.85(a)(5)(A) describes the purpose of the committee, which is to serve as a forum for discussion regarding transportation decisions affecting freight mobility and promote the sharing of information between public and private stakeholders on freight issues.

Section 1.85(a)(5)(B) describes the duties of the committee, which are to: 1) provide advice regarding freight-related priorities, issues, projects, and funding needs; 2) make recommendations regarding the creation of statewide freight transportation policies and performance measures; 3) make recommendations regarding the development of a comprehensive and multimodal statewide freight transportation plan; and 4) communicate and coordinate regional priorities with other organizations as requested by the department.

Section 1.85(a)(5)(C) provides for the manner of reporting and directs the committee to report its advice and recommendations to the executive director or designee, as well as to report to the commission when requested to do so.

FISCAL NOTE

James Bass, Chief Financial Officer, has determined that for each year of the first five years in which the proposed amendments are in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the amendments.

Marc Williams, Director of Planning, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the amendments.

PUBLIC BENEFIT AND COST

Mr. Williams has also determined that for each year of the first five years in which the amendments are in effect, the public benefit anticipated as a result of enforcing or administering the amendments will be better preparing the department for freight transportation challenges that it is likely to face over the coming years. There are no anticipated economic costs for persons required to comply with the sections as proposed. There will be no adverse economic effect on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the proposed amendments to §1.85 may be submitted to Robin Carter, Office of General Counsel, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78701-2483 or to RuleComments@txdot.gov with the subject line "1.85." The deadline for receipt of comments is 5:00 p.m. on March 18, 2013. In accordance with Transportation Code, §201.811(a)(5), a person who submits comments must disclose, in writing with the comments, whether the person does business with the department, may benefit monetarily from the proposed amendments, or is an employee of the department.

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission (commission) with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §201.117, which provides that the commission may establish, as it considers necessary, advisory committees on any of the matters under its jurisdiction.

CROSS REFERENCE TO STATUTE

Moving Ahead for Progress in the 21st Century, §1117.

§1.85. Department Advisory Committees.

(a) Creation.

(1) - (4) (No change.)

(5) Freight Advisory Committee.

(A) Purpose. The purpose of the Freight Advisory Committee is to serve as a forum for discussion regarding transportation decisions affecting freight mobility and promote the sharing of information between the private and public sectors on freight issues. The committee's advice and recommendations will provide the department with a broad perspective regarding freight transportation matters and assist in identifying potential freight transportation facilities that are critical to the state's economic growth and global competitiveness.

(B) Duties. The committee shall:

(i) provide advice regarding freight-related priorities, issues, projects and funding needs;

(ii) make recommendations regarding the creation of statewide freight transportation policies and performance measures;

(iii) make recommendations regarding the development of a comprehensive and multimodal statewide freight transportation plan; and

(iv) communicate and coordinate regional priorities with other organizations as requested by the department.

(C) Manner of reporting. The committee shall report its advice and recommendations to the executive director or a department employee designated by the executive director and shall make reports to the commission as requested.

(b) Operating procedures.

(1) Membership. Except as otherwise specified in this section, an advisory committee shall be composed of not more than 24 members to be appointed by the office or official to whom the committee is to report. When applicable to the purpose and duties of the committee, the membership shall provide a balanced representation between:

(A) industries or occupations regulated or directly affected by the department; and

(B) consumers of services provided either by the department or by industries or occupations regulated by the department.

(2) Meetings.

(A) An advisory committee shall meet once a calendar year and at such other times as requested by the office to which it reports.

(B) A majority of the membership of an advisory committee constitutes a quorum. A committee may take formal action only by majority vote of its membership.

(3) Officers. Each committee shall elect a chair and vice-chair by majority vote of the members of the committee.

(c) Duration. Except as otherwise specified in this section, a committee created under this section is abolished December 31, 2013, unless the commission amends its rules to provide for a different date.

(d) Reimbursement. The department may, if authorized by law and the executive director, reimburse a member of a committee for reasonable and necessary travel expenses. Current rules and laws governing reimbursement of expenses for state employees shall govern reimbursement of expenses for advisory committee members.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300414
Jeff Graham
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 463-8683

♦ ♦ ♦

CHAPTER 2. ENVIRONMENTAL REVIEW OF TRANSPORTATION PROJECTS

The Texas Department of Transportation (department) proposes amendments to §2.12, concerning Project Coordination; and §2.103, concerning Public Participation for an Environmental Impact Statement or Supplemental Environmental Impact Statement.

EXPLANATION OF PROPOSED AMENDMENTS

Transportation Code, §201.607 requires the department to adopt a memorandum of understanding (MOU) with each state agency that has responsibilities for the protection of the natural environment or for the preservation of historic or archeological resources. Transportation Code, §201.607 also requires the department to adopt the MOU and all revisions to it by rule and to periodically evaluate and revise the MOU. In order to meet the legislative intent and to ensure that natural resources are given full consideration in accomplishing the department's activities, the department is proposing the repeal of existing Subchapter B and simultaneously proposing new Subchapters G, H, and I, relating to Memorandum of Understanding with the Texas Parks and Wildlife Department, Memorandum of Understanding with the Texas Historical Commission, and Memorandum of Understanding with the Texas Commission on Environmental Quality, respectively.

The amendments change the current references to 43 TAC Chapter 2, Subchapter B in the department's rules so that the sections will reference the appropriate new provisions that are replacing Subchapter B. The amendments to §2.12(b) change the reference in that section from Subchapter B to new Subchapters G, H, and I. The amendments to §2.103(d)(2)(B) and (g)(2) change the references in those subsections from Subchapter B to new Subchapters G, H, and I.

FISCAL NOTE

James Bass, Chief Financial Officer, has determined that for each year of the first five years in which the proposed amendments are in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the amendments.

Jeff Graham, General Counsel, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the amendments.

PUBLIC BENEFIT AND COST

Mr. Graham has also determined that for each year of the first five years in which the amendments are in effect, the public benefit anticipated as a result of enforcing or administering the amendments will be accuracy in the department's rules related to memoranda of understanding with other state agencies concerning environmental review of transportation projects. There are no anticipated economic costs for persons required to comply with the sections as proposed. There will be no adverse economic effect on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the proposed amendments to §2.12 and §2.103 may be submitted to Robin Carter, Office of General Counsel, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78701-2483 or to RuleComments@txdot.gov with the subject line "2.12 and 2.103." The deadline for receipt of comments is 5:00 p.m. on March 18, 2013. In accordance with Transportation Code, §201.811(a)(5), a person who submits comments must disclose, in writing with the comments, whether the person does business with the department, may benefit monetarily from the proposed amendments, or is an employee of the department.

SUBCHAPTER A. GENERAL PROVISIONS

43 TAC §2.12

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE

Transportation Code, §201.607.

§2.12. Project Coordination.

(a) Participating agencies. A participating agency is any agency, department, or other unit of federal, state, local, or Indian tribal government, including a local flood control authority, that may have an interest in a transportation project, or that is a regulatory agency with jurisdiction over an aspect of the project. The project sponsor and department delegate will, in collaboration, identify the participating agencies for a project.

(b) Identification of participating agencies. The identification of participating agencies for a project will take into account the nature and extent of the project, the jurisdiction and interests of the agencies, whether the agencies have previously expressed interest in similar projects, and any laws requiring coordination with specific agencies. At a minimum, participating agencies will include the Texas Commission on Environmental Quality, the Texas Historical Commission, and the Texas Parks and Wildlife Department to the extent provided for in the [~~respective~~] memoranda of understanding under Subchapters G, H, and I, as appropriate, [~~Subchapter B~~] of this chapter (relating to Memorandum of Understanding with the Texas Parks and Wildlife Department, Memorandum of Understanding with the Texas Historical Commission, and Memorandum of Understanding with the Texas Commission on Environmental Quality, respectively [~~Memoranda of Understanding with Natural Resource Agencies~~]).

(c) - (g) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300415

Jeff Graham
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 463-8683

♦ ♦ ♦

SUBCHAPTER E. PUBLIC PARTICIPATION

43 TAC §2.103

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE

Transportation Code, §201.607.

§2.103. Public Participation for an Environmental Impact Statement or Supplemental Environmental Impact Statement.

(a) - (c) (No change.)

(d) Notice of availability of DEIS. Notice of availability of the DEIS will be made under this subsection after the DEIS is approved under §2.84(d) of this chapter (relating to Environmental Impact Statements).

(1) The department delegate will publish in the *Texas Register* a notice of availability that describes a circulation and comment period of not less than 45 days and that specifies where comments may be sent.

(2) The project sponsor will:

(A) transmit the DEIS directly to participating agencies;

(B) coordinate directly with participating agencies in accordance with the memoranda of understanding under Subchapters G, H, and I, [~~Subchapter B~~] of this chapter (relating to Memorandum of Understanding with the Texas Parks and Wildlife Department, Memorandum of Understanding with the Texas Historical Commission, and Memorandum of Understanding with the Texas Commission on Environmental Quality, respectively [~~Memoranda of Understanding with Natural Resource Agencies~~]), if applicable, memoranda of agreement, or other formal and informal agreements with those entities;

(C) publish in local newspapers a notice of availability that describes a circulation and comment period of not less than 45 days and that specifies where comments may be sent, unless there is no local newspaper in the area affected by the project, in which event the project sponsor will publish the notice of availability in a newspaper having general circulation in the area affected by the project; and

(D) coordinate directly with local agencies, including the appropriate metropolitan planning organization.

(e) - (f) (No change.)

(g) Notice of availability of FEIS. Notice of availability will be made under this subsection after the FEIS is approved under §2.84 of this chapter.

(1) The department delegate will publish notice of availability of the FEIS in the *Texas Register.* The project sponsor will provide, at a minimum, notice of availability of the FEIS to the metropolitan planning organization, publish the notice in a local newspaper having general circulation in the area affected by the project, and provide the notice to the local media through press release. If there is no local newspaper in the area affected by the project, the project sponsor will publish the notice in a newspaper having general circulation in the area affected by the project. The notice will:

(A) include information on obtaining copies; and

(B) state that the public will have not less than 30 days after the date of the publication of the notice in the *Texas Register* to submit comments, and explain how the public may submit comments.

(2) The project sponsor will coordinate directly with other governmental entities in accordance with memoranda of understanding under Subchapters G, H, and I, respectively [~~Subchapter B~~] of this chapter, if applicable, memoranda of agreement, or other formal and informal agreements with those entities.

(h) - (j) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300416
Jeff Graham
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 463-8683

♦ ♦ ♦

CHAPTER 2. ENVIRONMENTAL REVIEW OF TRANSPORTATION PROJECTS

The Texas Department of Transportation (department) proposes the repeal of §2.21, Purpose, and §2.22, Memorandum of Understanding with the Texas Parks and Wildlife Department. The department proposes the simultaneous replacement of the repealed sections with new Subchapter G, §§2.201 - 2.214, Memorandum of Understanding with the Texas Parks and Wildlife Department.

EXPLANATION OF PROPOSED REPEALS AND NEW SECTIONS

Transportation Code, §201.607 requires the department to adopt a memorandum of understanding (MOU) with each state agency that has responsibilities for the protection of the natural environment or for the preservation of historic or archeological resources. Transportation Code, §201.607 also requires the department to adopt the MOU and all revisions to it by rule and to periodically evaluate and revise the MOU. In order to meet the legislative intent and to ensure that natural resources are given full consideration in accomplishing the department's activities, the department has evaluated its MOU with the Texas Parks and Wildlife Department (TPWD) adopted in 1999 and finds it necessary to repeal existing §2.21 and §2.22 and simultaneously adopt new Subchapter G, §§2.201 - 2.214.

The proposed new MOU between TPWD and the department satisfies the statutory requirements for reviewing and revising MOUs with resource agencies. It is intended to replace the existing MOU, which has been in effect since March 21, 1999, with

an MOU that more effectively streamlines TPWD's review of the department's projects and simultaneously better allows TPWD to focus on those projects most likely to affect natural resources. The proposed MOU has several new provisions and procedures that were developed based on experience gained from numerous projects that the department has submitted and TPWD has reviewed since the 1999 MOU was executed. It is also better organized than the existing MOU, with different subject areas broken into separate sections. Additionally, the proposed MOU reflects changes made by the department's recent revision of its environmental review rules, published in the March 9, 2012, issue of the *Texas Register* (37 TexReg 1727).

SECTION BY SECTION EXPLANATION OF PROPOSED MOU

Section 2.201 sets out the purpose of the MOU and explains that it supersedes various other MOUs previously entered into by the department and TPWD. Section 2.201 also requires the MOU to be updated within five years of its effective date, as required by Transportation Code, §201.607.

Section 2.202 sets forth the applicability of the MOU by identifying the types of transportation projects that must be evaluated under the MOU. Maintenance projects for which a programmatic environmental review is conducted under 43 TAC §2.133 are not required to be evaluated under the MOU.

Section 2.203 contains definitions of various terms used in the MOU.

Section 2.204 sets parameters on the department's use of the Texas Natural Diversity Database (TXNDD) maintained by TPWD, a database of information about listed and proposed threatened and endangered species and other features of Texas natural history. The section also requires the department to report observations of certain species to TPWD using TXNDD reporting forms.

Section 2.205 sets forth procedures for determining whether the department is required to coordinate a given transportation project with TPWD. It requires the department to perform a Tier I site assessment on each project to which the MOU applies as set forth in §2.202. The department then compares the results of the Tier I site assessment to triggers listed in §2.206 and thresholds identified in a programmatic agreement developed under §2.213 to determine whether coordination is required.

Section 2.206 contains triggers for determining when coordination is required using the procedures identified in §2.205. For example, coordination is required if a project will directly impact known isolated wetlands outside the existing department right-of-way. Use of these triggers, and the thresholds identified in a programmatic agreement developed under §2.213, will allow TPWD to focus its resources on reviewing those projects most likely to adversely affect natural resources.

Section 2.207 explains the process for early coordination of a project between TPWD and the department. It is the intention of the department and TPWD that early coordination, as opposed to administrated coordination under §2.208, will be the primary mechanism for coordination of projects between the agencies. In conducting early coordination, the department provides project documentation to TPWD, and TPWD provides determinations and recommendations to the department. The results of early coordination are then summarized in the project's environmental review document. The process for early coordination is less formal than the process for administrated coordination, explained in the following section.

Section 2.208 explains the process for administrated coordination, which must be conducted for projects subject to coordination under §2.205, but for which early coordination under §2.207 is not conducted. Administrated coordination requires the department to submit to TPWD a coordination package consisting of a cover letter, a Tier II site assessment, and other studies or reports the department believes are relevant. TPWD then has 45 days to comment on any aspect of the project it determines may have adverse impacts to fish and wildlife resources. Within 90 days of making a decision related to a written comment made by TPWD, the department must provide TPWD with a written explanation of the department's decision or other action. Also, as with early coordination, the results of administrated coordination must be summarized in the project's environmental review document.

Section 2.209 explains Tier II site assessments, which are the primary environmental reports prepared by the department and reviewed by TPWD during administrated coordination, and provides the minimum required elements of a Tier II site assessment.

Section 2.210 requires the department to communicate with TPWD when unforeseen impacts are identified during construction of a project.

Section 2.211 requires the department to maintain records of projects that are subject to the MOU and to respond within 30 days to any request made by TPWD to review project records.

Section 2.212 allows TPWD to make site visits to department project sites.

Section 2.213 requires the department and TPWD to develop certain programmatic agreements addressing issues not covered in the MOU. The section describes six specific programmatic agreements that must be developed by the department and TPWD.

Section 2.214 requires the department and TPWD to appoint an interagency MOU implementation team to fulfill various functions related to implementing the MOU, such as developing the programmatic agreements required by §2.213, preparing recommendations for the next update of the MOU, and developing metrics for tracking the effectiveness of the MOU.

FISCAL NOTE

James Bass, Chief Financial Officer, has determined that for each year of the first five years in which the new subchapter as proposed is in effect, there will be fiscal implications for state government as a result of enforcing or administering the new subchapter. New §2.213 requires the department and TPWD to develop a programmatic agreement concerning department-funded positions at TPWD. The goal of this programmatic agreement will be to reduce the number of projects referred to TPWD for coordination by 50 percent, reduce average project review times, and increase the environmental value of project mitigation. Reasonably assuming for the purpose of this analysis that this programmatic agreement would result in the department's funding of two full-time employees at TPWD, this would require an expenditure of approximately $167,797 annually from the State Highway Fund. This expenditure is expected to be offset by the benefit of more efficient and timely environmental review of the department's projects by TPWD. There are no anticipated fiscal implications for local governments as a result of enforcing or administering the new subchapter. There

are no economic costs for persons required to comply with the new subchapter.

Carlos Swonke has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the new subchapter.

PUBLIC BENEFIT AND COST

Mr. Swonke has also determined that for each year of the first five years in which the new subchapter is in effect, the public benefit anticipated as a result of enforcing or administering the new subchapter will be increased efficiency in completing the environmental review of the department's projects, and more effective coordination with TPWD on the department's projects. There are no anticipated economic costs for persons required to comply with the sections as proposed. There will be no adverse economic effect on small businesses.

COASTAL MANAGEMENT PROGRAM CONSISTENCY REVIEW

The department determined that this rulemaking relates to actions subject to the Texas Coastal Management Program (CMP) under the Coastal Coordination Act of 1991, as amended (Natural Resources Code, §§33.201 et seq.), and must be consistent with all applicable CMP policies, because it concerns the department's environmental review of transportation projects. The department reviewed this action for consistency with the CMP goals and policies under the rules promulgated by the Coastal Coordination Council, which remain in effect until superseded by rules of the General Land Office. The department has determined that the action is consistent with applicable CMP goals and policies.

A CMP policy applicable to this rulemaking is that transportation projects shall comply with certain practices concerning the siting of a project to lessen the impacts on coastal natural resources (see 31 TAC §501.31). The proposed rules concern the method by which to evaluate the environmental impacts of a transportation project and do not dictate the siting of a project. However, the purpose of the proposed rules is to establish procedures for identifying the impacts of transportation projects on certain resources and for coordination of projects with the relevant state resource agency. This provides an additional mechanism for avoiding, minimizing, or mitigating, where practicable, adverse effects of department projects on coastal natural resource areas that serve as habitat, on coastal preserves, and on threatened and endangered species. For these reasons, the rulemaking action is consistent with the CMP goal of protecting, preserving, restoring, and enhancing the diversity, quality, quantity, functions, and values of coastal natural areas.

A copy of this rulemaking will be submitted to the General Land Office for its comments on the consistency of the proposed rulemaking with the CMP. The department requests that the public also give comment on whether the proposed rulemaking is consistent with the CMP.

PUBLIC HEARING

Pursuant to the Administrative Procedure Act, Government Code, Chapter 2001, the Texas Department of Transportation will conduct a public hearing to receive comments concerning the proposed rules. The public hearing will be held at 1:30 p.m. on March 7, 2013, in the Ric Williamson Hearing Room, First Floor, Dewitt C. Greer State Highway Building, 125 East 11th Street, Austin, Texas and will be conducted in accordance with the procedures specified in 43 TAC §1.5. Those desiring to make comments or presentations may register starting at 1:00 p.m. Any interested persons may appear and offer comments, either orally or in writing; however, questioning of those making presentations will be reserved exclusively to the presiding officer as may be necessary to ensure a complete record. While any person with pertinent comments will be granted an opportunity to present them during the course of the hearing, the presiding officer reserves the right to restrict testimony in terms of time and repetitive content. Organizations, associations, or groups are encouraged to present their commonly held views and identical or similar comments through a representative member when possible. Comments on the proposed text should include appropriate citations to sections, subsections, paragraphs, etc. for proper reference. Any suggestions or requests for alternative language or other revisions to the proposed text should be submitted in written form. Presentations must remain pertinent to the issues being discussed. A person may not assign a portion of his or her time to another speaker. Persons with disabilities who plan to attend this meeting and who may need auxiliary aids or services, such as interpreters for persons who are deaf or hearing impaired, readers, large print or Braille, are requested to contact Government and Public Affairs Division, 125 East 11th Street, Austin, Texas 78701-2483, (512) 463-6086, at least five working days prior to the hearing so that appropriate services can be provided.

SUBMITTAL OF COMMENTS

Written comments on the proposed repeal of §2.21 and §2.22 and simultaneous replacement of the repealed sections with new Subchapter G, §§2.201 - 2.214 may be submitted to Robin Carter, Office of General Counsel, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78701-2483 or to RuleComments@txdot.gov with the subject line "TPWD MOU." The deadline for receipt of comments is 5:00 p.m. on March 18, 2013. In accordance with Transportation Code, §201.811(a)(5), a person who submits comments must disclose, in writing with the comments, whether the person does business with the department, may benefit monetarily from the proposed rules, or is an employee of the department.

SUBCHAPTER B. MEMORANDA OF UNDERSTANDING WITH NATURAL RESOURCE AGENCIES

43 TAC §2.21, §2.22

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Department of Transportation or in the Texas Register office, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

STATUTORY AUTHORITY

The repeals are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §201.607(b), which requires the department to adopt memoranda of understanding with each agency that has responsibility for the protection of the natural environment or for the preservation of historical or archeological resources and to adopt all revisions to these memoranda by rule.

CROSS REFERENCE TO STATUTE

Transportation Code, §201.607.

§2.21. Purpose.

§2.22. Memorandum of Understanding with the Texas Parks and Wildlife Department.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300407
Jeff Graham
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 463-8683

♦ ♦ ♦

SUBCHAPTER G. MEMORANDUM OF UNDERSTANDING WITH THE TEXAS PARKS AND WILDLIFE DEPARTMENT

43 TAC §§2.201 - 2.214

STATUTORY AUTHORITY

The new sections are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §201.607(b), which requires the department to adopt memoranda of understanding with each agency that has responsibility for the protection of the natural environment or for the preservation of historical or archeological resources and to adopt all revisions to these memoranda by rule.

CROSS REFERENCE TO STATUTE

Transportation Code, §201.607.

§2.201. Purpose.

(a) Transportation Code, §201.607, requires the Texas Department of Transportation (TxDOT) to adopt a memorandum of understanding (MOU) with each state agency that has responsibilities for the protection of the natural environment or for the preservation of historical or archeological resources, and requires TxDOT and each of the agencies to adopt the memoranda and all revisions by rule. This subchapter contains the memorandum of understanding between TxDOT and the Texas Parks and Wildlife Department (TPWD) that implements that section.

(b) This subchapter furthers the environmental policy of TxDOT to protect, preserve, and when possible, enhance the environment, and the responsibility of TPWD for protecting the state's fish and wildlife resource.

(c) This MOU supersedes the MOU that was adopted to be effective March 21, 1999; the Memoranda of Agreement for the Finalization of 1998 MOU Concerning Habitat Descriptions and Mitigation that was signed August 2, 2001; the MOU Regarding Mitigation Banking that was signed December 7, 2005; and the Memorandum of Agreement for Sharing and Maintaining Natural Diversity Database Information that was signed April 11, 2007. Nothing in this subchapter supersedes, modifies, or nullifies any other agreement entered into by TxDOT and TPWD.

(d) TxDOT and TPWD shall review and by rule shall update this MOU not later than the fifth anniversary of its effective date, as required by Transportation Code, §201.607.

§2.202. Applicability.

(a) Except as provided in subsection (b) of this section, this subchapter applies to:

(1) a state transportation project or Federal Highway Administration (FHWA) transportation project conducted by the Texas Department of Transportation (TxDOT);

(2) a state transportation project or FHWA transportation project of a private or public entity that is funded in whole or in part by TxDOT;

(3) a state transportation project or FHWA transportation project of a private or public entity that requires Texas Transportation Commission or TxDOT approval;

(4) a maintenance program for which a programmatic environmental review is conducted under §2.133 of this chapter (relating to Maintenance Projects and Programs); or

(5) any other type of project coordinated at TxDOT's request.

(b) This subchapter does not apply to individual maintenance projects for which a programmatic environmental review is conducted under §2.133 of this chapter.

§2.203. Definitions.

The following words and terms, when used in this subchapter, or in documents prepared by the Texas Department of Transportation (TxDOT) or Texas Parks and Wildlife Department (TPWD) pursuant to this subchapter, have the following meanings.

(1) Coordination--Actions between TxDOT and TPWD that relate to and facilitate TPWD's review of and comments on the potential environmental effects of a transportation project. The goal of coordination is to minimize adverse impacts of transportation projects on the fish and wildlife resources of Texas while maximizing efficient use of each agency's resources.

(2) Best management practices (BMPs)--Actions taken to minimize the adverse effects of transportation projects on fish and wildlife resources.

(3) Ecological Mapping Systems of Texas (EMST)--An on-going effort to map vegetation of Texas at high resolution using multi-spectral aerial imagery and intensive on-ground verification.

(4) Environmental report--A report, form, checklist, or other documentation analyzing an environmental issue in the context of a specific transportation project or presenting a thorough summary of an environmental study conducted in support of an environmental review document, or demonstrating compliance with a specific environmental requirement. The term does not include a permit or other approval outside the scope of the environmental review process.

(5) Environmental review document--An environmental assessment, an environmental impact statement, a reevaluation, a supplemental environmental impact statement, or, for an FHWA transportation project, a document prepared to demonstrate that it qualifies as a categorical exclusion when FHWA requires a narrative document as opposed to a checklist. An environmental review document includes any attached environmental reports.

(6) Federal Highway Administration (FHWA)--The United States Department of Transportation Federal Highway Administration.

(7) FHWA transportation project--A transportation project for which FHWA's approval is required by law to comply with NEPA, FHWA is the lead federal agency, and FHWA agrees TxDOT may act as the joint lead agency under 23 Code of Federal Regulations §771.109.

(8) Important remnant vegetation--A type of vegetation that is considered by TPWD to be rare, have local value, or to have substantially declined in recent times. This includes vegetation communities listed in the TCAP as of special conservation concern, or as S3 or rarer, and communities listed as suitable habitat and within the range of any Species of Greatest Conservation Need (SGCN). For the purposes of this MOU, in the event there is a range rank (e.g. S3S4) the lower rank should be used in determining the rarity of the community.

(9) Mitigation--For the purpose of this MOU, the actions taken to reduce the adverse impacts to the natural environment that result directly from a transportation project. The term includes actions taken to avoid, minimize, or to compensate for impacts.

(10) NEPA--The National Environmental Policy Act, codified at 42 United States Code §§4321, et seq.

(11) Plant community association--A plant community of definite floristic composition (dominant/diagnostic species), uniform habitat conditions, and uniform physiognomy.

(12) Qualified biologist--A qualified biologist must have, at a minimum, a successful completion of a full 4-year course of study in an accredited college or university leading to a bachelor's or higher degree with a major in biological sciences, natural resource management, wildlife science or management, ecology, zoology, botany, conservation biology, or a closely related field and have experience relevant to the species, habitat, or ecosystems that are being studied or described.

(13) Range--The general area where a species would be expected to occur as listed by county on the TPWD website or where available, as shown in range maps provided in or referenced by the TCAP.

(14) Right of way--Property acquired for the purpose of a transportation project.

(15) Riparian vegetation--River- or creek-dependent habitats which rely on periodic flooding or flushing, sub-irrigated substrates, and other influences of the ephemeral or perennial rivers or creeks to which they are adjacent, including floodplains, wet woodlands, gallery riverine forests, oxbows, swamps, and vegetated islands.

(16) Species of Greatest Conservation Need (SGCN)--Species of plants or animals that are identified in the TCAP.

(17) State threatened or endangered species--A species of wildlife listed as threatened in 31 TAC §65.175 (relating to Threatened Species) or as endangered in 31 TAC §65.176 (relating to Endangered Species), or a plant species listed as threatened or endangered in 31 TAC §69.8 (relating to Endangered and Threatened Plants).

(18) State transportation project--A transportation project that is not a major federal action for the purpose of NEPA.

(19) Suitable habitats--Habitats that provide a species or community with the specific physical location and conditions needed to survive and persist. These may include terrestrial and aquatic vegetation communities; a particular watershed, waterbody or stream segment; water quantity or quality thresholds; particular geologic substrates (such as limestone, granite, and sands) or formations (such as karst and caves); or a species host.

(20) Texas Conservation Action Plan (TCAP)--The natural resources conservation plan for the State of Texas. The TCAP identifies fish and wildlife resources of the state, including SGCN and their habitats, outlines activities to improve SGCN status and prevent federal threatened or endangered species listings where possible, and articulates conservation needs. The TCAP is stewarded by TPWD and implemented across the state by TPWD and conservation partners. The TCAP provides definitions for ecological systems, plant community associations, and habitats which are important for SGCN.

(21) Tier I site assessment--A preliminary site assessment to determine impacts and coordination requirements with TPWD.

(22) Tier II site assessment--An environmental report that demonstrates quantitative (acres) and qualitative (high, medium, or low) determination of ecological systems and plant community associations affected by a transportation project. Tier II site assessments require an on-site verification by a qualified biologist to the extent access to new right of way is available.

(23) TPWD--Texas Parks and Wildlife Department.

(24) TxDOT--Texas Department of Transportation.

(25) Transportation enhancement--An activity that is listed under 23 United States Code §101(a)(35), relates to a transportation project, and is eligible for federal funding under 23 United States Code §133.

(26) Transportation project--A project to construct, maintain, or improve a highway, rest area, toll facility, aviation facility, public transportation facility, rail facility, ferry, or ferry landing. A transportation enhancement is also a transportation project.

(27) Wetland--An area (including a swamp, marsh, bog, prairie pothole, or similar area) having a predominance of hydric soils that are inundated or saturated by surface or groundwater at a frequency and duration sufficient to support, and that under normal circumstances does support, the growth and regeneration of hydrophytic vegetation.

§2.204. Texas Natural Diversity Database (TXNDD).

(a) TPWD maintains the TXNDD. The TXNDD contains information on listed and proposed threatened and endangered species, both state and federal, SGCN, important remnant native vegetation, and other features of Texas natural history. TPWD will continue to provide TXNDD information to TxDOT.

(b) This MOU authorizes certain limited use and distribution of this information, and specifies security requirements. The mechanisms established for transferring electronic TXNDD information from TPWD to TxDOT will be used to transfer electronic information relevant to this subchapter, such as TCAP data and EMST data.

(c) The TXNDD is the property of TPWD.

(d) Except as provided in subsection (e) of this section, TxDOT will not release the TXNDD or any portion of it to outside parties unless TxDOT receives a request under the Texas Public Information Act for the TXNDD or information contained therein, in which case TxDOT will notify TPWD of the request.

(e) Texas Public Information Act requests for copies of approved environmental review documents and environmental reports that contain information from the TXNDD do not require TPWD notification.

(f) TxDOT will conduct training on access and use of the TXNDD as it relates to transportation projects. The training will be developed jointly by TxDOT and TPWD.

(g) TxDOT will provide completed TXNDD reporting forms for observations of tracked SGCN occurrences within TxDOT project areas.

(h) TXNDD reporting requirements shall be incorporated into the site assessment protocol.

§2.205. Determining Need for TPWD Coordination.

(a) TxDOT will perform a Tier I site assessment for all projects subject to this subchapter.

(1) A Tier I site assessment is used to determine impacts and the need for coordination with TPWD. The Tier I site assessment will define the type and amount of habitat impacted using information from TCAP, EMST, TXNDD, county lists of Rare and Protected Species of Texas maintained by TPWD; county lists of endangered, threatened, and candidate species maintained by the U.S. Fish and Wildlife Service; and the most current aerial photography available. The results of a Tier 1 assessment will be recorded in the Texas ECOS project file.

(2) TxDOT will compare the results of a Tier I site assessment to the triggers in §2.206 of this subchapter (relating to Coordination Triggers) and thresholds found in the Threshold Table Programmatic Agreement developed under §2.213 of this subchapter (relating to Programmatic Agreements) to determine the need for coordination with TPWD.

(3) Tier I site assessments may require a field visit by a TxDOT qualified biologist to resolve the level of impact and, therefore, the requirement to coordinate a project with TPWD.

(b) TxDOT will coordinate with TPWD under §2.207 of this subchapter (relating to Early Project Coordination) or §2.208 of this subchapter (relating to Administrated Project Coordination) concerning a proposed transportation project if a trigger under §2.206 is met or a threshold found in the Threshold Table Programmatic Agreement developed under §2.213 is exceeded, and one of the following conditions is also met:

(1) the project has not previously completed coordination;

(2) the project has been previously reviewed by TPWD but is the subject of a reevaluation or revision and the scope of the reevaluation or revision relates to an issue on which TPWD commented; or

(3) the project has been previously reviewed by TPWD but is the subject of a reevaluation or revision and the change proposed in the reevaluation or revision, considered as a stand-alone transportation project, is a substantial change to the project from the previous coordination.

(c) For the purposes of subsection (b) of this section, a change is substantial if it is equal to or greater than at least one of the factors listed in §2.206 of this subchapter, or the proposed new impacts would be greater than had previously been coordinated or now exceed a threshold found in the Threshold Table Programmatic Agreement developed under §2.213 of this subchapter. These changes can include, but are not limited to, increased impacts to fish and wildlife resources or rare vegetation series identified in the TCAP, changes in the status of such resources since the previous coordination, or the identification of a new TXNDD record or records of rare or protected species or managed areas that may be impacted and that are different than those identified when coordination was previously conducted.

(d) No coordination under this MOU is required for a project that is not described by subsection (b) of this section.

§2.206. Coordination Triggers.

The triggers described in this section shall be used to determine whether coordination is required as provided by §2.205 of this subchapter (relating to Determining Need for TPWD Coordination).

(1) The project is within the range of a state threatened or endangered species or SGCN as identified by the TPWD County list of Rare and Protected Species, and there is suitable habitat, unless BMPs as defined in this MOU are implemented as provided by a programmatic agreement developed under §2.213 of this subchapter (relating to Programmatic Agreements).

(2) The project may adversely impact important remnant vegetation based on the judgment of a qualified biologist or as mapped in the TXNDD.

(3) The project requires a nationwide permit with pre-construction notification or an individual permit, issued by the United States Army Corps of Engineers.

(4) The project includes in the TxDOT right of way or conservation, construction, or drainage easement more than 200 linear feet of stream channel for each single and complete crossing of one or more of the following that is not already channelized or otherwise maintained:

(A) channel realignment; or

(B) stream bed or stream bank excavation, scraping, clearing, or other permanent disturbance.

(5) The project contains known isolated wetlands outside existing TxDOT right of way that will be directly impacted by the project.

(6) The project may impact 0.10 acre of riparian vegetation based on the judgment of a qualified biologist or as mapped in the EMST.

(7) The project disturbs habitat in an area equal to or greater than the area of disturbance indicated in the Threshold Table Programmatic Agreement developed under §2.213 of this subchapter.

§2.207. Early Project Coordination.

(a) It is the intention of TxDOT and TPWD that coordination during early project development will be the primary mechanism for coordination of projects between the agencies.

(b) To request early project coordination, TxDOT will provide available and relevant project information to TPWD. TxDOT and TPWD will work cooperatively to identify any additional documentation appropriate for review and comment on the project.

(c) TPWD will notify TxDOT when documentation is sufficient to conduct early project coordination. Upon completion of the review, TPWD will provide determinations and recommendations to TxDOT. Upon TPWD submission of determinations and recommendations and TxDOT written response in accordance with Parks and Wildlife Code, §12.0011(c), early project coordination is complete.

(d) TPWD determinations and recommendations must be issued by the TPWD Wildlife Habitat Assessment Program, and TxDOT written responses must be issued by TxDOT's Environmental Affairs Division. All other communications during early project coordination may be made by other appropriate organizational units of the respective agencies or other entities approved by the respective agencies. TxDOT's Environmental Affairs Division and the TPWD Wildlife Habitat Assessment Program are each responsible for identifying its respective agency's rules and requirements.

(e) TxDOT may make project modifications and request additional TPWD comment. TPWD may review final project documents and final environmental review documents.

(f) Projects for which early project coordination is completed do not require additional coordination unless project modifications warrant re-coordination under §2.205(b)(2) or (3) of this subchapter (relating to Determining Need for TPWD Coordination).

(g) The TxDOT department delegate for the project will ensure that the results of any coordination with TPWD, including efforts made by TxDOT during project planning and design to avoid and minimize impacts to natural resources, shall be summarized in the project's environmental review document.

§2.208. Administrated Project Coordination.

(a) Administrated project coordination will be conducted for projects subject to coordination under this MOU, but for which early project coordination is not completed.

(b) Administrated project coordination will occur between TxDOT's Environmental Affairs Division and the TPWD Wildlife Habitat Assessment Program, unless those two units agree in writing to allow other appropriate organizational units of the respective agencies or other entities approved by the respective agencies to conduct the coordination. TxDOT's Environmental Affairs Division and the TPWD Wildlife Habitat Assessment Program are each responsible for identifying its respective agency's rules and requirements.

(c) To initiate administrated project coordination, TxDOT will submit the coordination package to TPWD for review and comment. The coordination package consists of a cover letter that requests review pursuant to this MOU, the Tier II site assessment, and any other environmental studies or reports that TxDOT believes are relevant to TPWD's review of the project. This coordination package is prepared and submitted to TPWD prior to the environmental document being produced.

(d) Texas ECOS is a web-based relational database for electronic communication and tracking of environmental coordination. TPWD will be provided access with user privileges to Texas ECOS with the intention of making information exchange paperless and real time. Until TPWD has provided written agreement that Texas ECOS is adequate for TPWD coordination review, all administrated coordination will be conducted in writing and transmitted on agency letterhead.

(e) TPWD will comment on any aspect of the project it determines may have adverse impacts to fish and wildlife resources.

(f) For written communications, TPWD shall have 45 days from the date TxDOT receives written confirmation that TPWD has received the coordination package for its review, or five business days after the date of transmittal of the coordination package, whichever occurs first, to provide its comments on the project. Once Texas ECOS is accepted as the means for communicating and tracking project coordination, the 45-day clock will start on the first business day after notification to TPWD that the coordination information is available in ECOS.

(g) TPWD may request additional information during the 45-day review period, in which case TxDOT will provide the requested information if the information is available or can be reasonably obtained. If the requested information cannot be provided, then TxDOT will inform TPWD and explain why in writing.

(h) TxDOT will consider and implement when mutually agreeable, the comments that are submitted by TPWD within the 45-day review period. TxDOT will provide TPWD with a written explanation of TxDOT's decisions or other action within 90 days of making a decision related to the comment.

(i) If TPWD submits comments after the end of the 45-day review period, TxDOT will consider the comments in making decisions on the project to the extent practicable, and provide a written response in the same manner indicated in subsection (e) of this section.

(j) The TxDOT department delegate for the project will ensure that the results of any coordination with TPWD, including efforts made by TxDOT during project planning and design to avoid and minimize impacts to natural resources, shall be summarized in the project's environmental review document.

§2.209. Tier II Site Assessment.

(a) Tier II site assessments are the basis for evaluating project impacts and are the primary environmental report used for administrated coordination under this subchapter. A programmatic agreement will be developed and approved to provide implementation requirements for site assessments.

(b) A Tier II site assessment will be prepared for those projects that are subject to coordination under this MOU and for which early project coordination is not completed.

(c) A Tier II site assessment must include a review of the TCAP and documentation of the direct impacts from the project to ecosystems, plant community associations, preferred habitat for SGCN that are within range, easements, and land set aside for environmental mitigation. Additionally, a TxDOT qualified biologist will provide field verification to confirm potential direct and indirect impacts, assess the quality of impacted fish and wildlife resources, and determine the areal extent of ecological systems and plant community associations for the entire project area, and whether any or all of the project may result in adverse impacts to fish and wildlife resources.

(d) At a minimum, Tier II site assessments will include:

(1) a description of the project, including the natural setting in which the project occurs, the existing conditions, and the proposed action;

(2) a description of the quantity and quality of any habitat that occurs for species on the county list within or abutting the right of way; and

(3) any proposed steps to be taken to mitigate potential adverse impacts on resources.

(e) Protocols for review of TXNDD information and an interpretation of the data will be included in the site assessment programmatic agreement.

(f) It is understood that a lack of access to the new right of way may limit the amount of information available for the habitat description. Existing data shall be used to provide a best estimate in these circumstances.

§2.210. Communication during Construction.

(a) TxDOT will communicate with TPWD when unforeseen impacts on species that are included on TPWD county lists or their habitat are identified during construction of a project.

(b) TPWD and TxDOT will conduct site visits at the request of either party and upon scheduling agreement of both parties.

§2.211. Project Tracking.

TxDOT will maintain records of all projects subject to this subchapter. TPWD may request information electronically from TxDOT until Texas ECOS is operational at TPWD offices. The information request

should specify time ranges and geographic areas for the records. TxDOT will respond within 30 days of the request.

§2.212. Site Access.

TPWD may make site visits to any TxDOT construction or maintenance site. TPWD must provide TxDOT timely notification of its intention to conduct an on-site visit to an ongoing construction site and must comply with all safety requirements identified in TxDOT's response or as instructed by the on-site responsible person.

§2.213. Programmatic Agreements.

(a) The Interagency MOU Implementation Team created under §2.214 of this subchapter (relating to Interagency MOU Implementation Team) will develop programmatic agreements to address issues not specifically identified in this subchapter. Programmatic agreements must be approved by the Executive Director of each agency prior to their effective date.

(b) At a minimum, the Interagency MOU Implementation Team will develop programmatic agreements described in this subsection.

(1) A programmatic agreement detailing the information required to be included in a Tier II site assessment will be developed. This programmatic agreement will set forth the Tier II site assessment requirements in greater detail than that provided in §2.209 of this subchapter (relating to Tier II Site Assessment).

(2) A threshold table programmatic agreement will be developed to establish thresholds to be used in making the determination required by §2.205 of this subchapter (relating to Determining Need for TPWD Coordination).

(3) A programmatic agreement concerning TxDOT-funded positions at TPWD will be developed. The goal of this programmatic agreement will be to reduce the number of projects referred to TPWD for coordination by 50 percent, reduce average project review times, and increase the environmental value of project mitigation.

(4) A programmatic agreement for updating and supporting the TXNDD to be a best in class resource will be developed.

(5) A programmatic agreement concerning conservation projects will be developed.

(6) A programmatic agreement concerning BMPs will be developed. The interagency team will develop new BMPs for adoption by TxDOT and TPWD to reduce the number of projects referred to TPWD as a result of meeting triggers for state threatened or listed species, and other triggers as appropriate, and to further mitigate the adverse impacts of transportation projects.

(c) Programmatic agreements may be changed at any time by the written concurrence of the Executive Directors of TxDOT and TPWD.

§2.214. Interagency MOU Implementation Team.

(a) The Executive Directors of TxDOT and TPWD or their delegates shall mutually appoint an interagency team which will be formed within two months of the effective date of this MOU and will meet, at a minimum, quarterly for the first two years of implementation of this MOU, and on a semi-annual basis thereafter, unless a majority of the team deems it necessary to meet more frequently.

(b) The interagency team will prepare recommendations for the next update of this MOU.

(c) The interagency team will develop metrics for tracking the effectiveness of this MOU and will provide an annual report to the leadership of TxDOT and TPWD. This report will include, at a minimum, the actual number of projects coordinated, the reduction in the number of projects coordinated as a result of changes to the environmental review process effectuated by this MOU, an analysis of the time to complete project coordination, the adverse impacts of transportation projects by habitat type, the conservation of habitat resulting from mitigation, evaluation of the value of any TxDOT-funded positions at TPWD, and recommendations regarding continuation of those positions.

(d) The interagency team will evaluate and make recommendations to improve the usefulness and applicability of TPWD comments.

(e) The interagency team will facilitate reviews and comments on agency guidance and protocols developed to implement this MOU.

(f) The interagency team shall review the early project coordination process periodically and make recommendations for improving process efficiency and usefulness. The interagency team will be responsible for attempting to resolve any conflict between TPWD and TxDOT that results from the implementation of this subchapter before elevating to agency management.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300408
Jeff Graham
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 463-8683

♦ ♦ ♦

CHAPTER 2. ENVIRONMENTAL REVIEW OF TRANSPORTATION PROJECTS

The Texas Department of Transportation (department) proposes the repeal of §2.23, concerning Memorandum of Understanding with the Texas Natural Resource Conservation Commission. The department proposes the simultaneous replacement of the repealed section with new Subchapter I, §§2.301 - 2.308, concerning Memorandum of Understanding with the Texas Commission on Environmental Quality.

EXPLANATION OF PROPOSED REPEAL AND NEW SECTIONS

Transportation Code, §201.607 requires the department to adopt a memorandum of understanding (MOU) with each state agency that has responsibilities for the protection of the natural environment or for the preservation of historic or archeological resources. Transportation Code, §201.607 also requires the department to adopt the MOU and all revisions to it by rule and to periodically evaluate and revise the MOU. In order to meet the legislative intent and to ensure that natural resources are given full consideration in accomplishing the department's activities, the department has evaluated its MOU with the Texas Commission on Environmental Quality (TCEQ) adopted in 2002, and finds it necessary to repeal existing §2.23 and simultaneously propose new Subchapter I, §§2.301 - 2.308.

The proposed new MOU between TCEQ and the department satisfies the statutory requirements for reviewing and revising MOUs with resource agencies. It is intended to replace the existing MOU, which has been in effect since March 21, 2002, with an MOU that more effectively streamlines TCEQ's review of the department's projects and simultaneously better allows TCEQ to focus on those projects most likely to affect natural resources. The proposed MOU is better organized than the existing MOU, with different subject areas broken into separate sections. The proposed MOU recognizes that the legislature changed the name of the Texas Natural Resource Conservation Commission to the Texas Commission on Environmental Quality. Additionally, the proposed MOU reflects changes made by the department's recent revision of its environmental review rules, published in the March 9, 2012, issue of the *Texas Register* (37 TexReg 1727).

SECTION BY SECTION EXPLANATION OF PROPOSED MOU

Section 2.301 sets out the purpose of the MOU, to provide a formal mechanism by which TCEQ reviews transportation projects that have the potential to affect resources within TCEQ's jurisdiction.

Section 2.302 sets forth the statutory authority for TxDOT and TCEQ to enter into the MOU.

Section 2.303 contains definitions of various terms used in the MOU.

Section 2.304 sets forth the statutory responsibilities of TxDOT and TCEQ that are relevant to the purpose of the MOU.

Section 2.305 sets forth procedures for determining whether the department is required to coordinate a given transportation project with TCEQ. TxDOT will not coordinate a project that TxDOT classifies as a categorical exclusion, blanket categorical exclusion, or programmatic categorical exclusion under §2.81 or §2.82 of Chapter 2. TxDOT will coordinate a project for which TxDOT prepares an environmental assessment unless TxDOT has already coordinated an environmental report (discussed below) concerning the project and certain other conditions are met. TxDOT will coordinate a project for which TxDOT prepares an environmental impact statement. TxDOT will coordinate a reevaluation concerning a project if the earlier coordination concerning the project is no longer valid as a result of changes in the project.

Section 2.305(a) recognizes TxDOT's new procedures that allow TxDOT to prepare an environmental report, which is a report, form, checklist, or other documentation analyzing an environmental issue in the context of a specific transportation project or presenting a thorough summary of an environmental study conducted in support of an environmental review document, or demonstrating compliance with a specific environmental requirement. TxDOT's recently-adopted rules authorize a project sponsor to prepare an environmental report and submit it for technical review before the environmental review document is completed (see 43 TAC §2.45). Similarly, the proposed MOU would allow, but not require, TxDOT to coordinate separately an environmental report with TCEQ. For projects for which TxDOT prepares an environmental assessment, the MOU would allow TxDOT to satisfy coordination requirements by coordinating an environmental report provided all of the conditions in proposed §2.305(a)(2)(B) are met.

Section 2.305(b) contains triggers for determining when coordination is required for projects for which TxDOT prepares an environmental assessment. For example, coordination is required if a project will add capacity in a nonattainment or maintenance area of the state. Use of these triggers will allow TCEQ to focus its resources on reviewing those projects most likely to adversely affect natural resources.

Section 2.305(c) includes general provisions concerning compliance with law and the computation of time. The proposed MOU would authorize TxDOT (but not a local government) to conduct the coordination with TCEQ.

Section 2.305(d) specifies the protocols for TxDOT transmitting an environmental report or environmental review document to TCEQ, and then TCEQ transmitting back its comments on the document. TCEQ must submit is comments within 30 days, unless TCEQ gives notice that it is extending the deadline for no more than an additional 15 days. TxDOT will respond in writing to TCEQ's comments, and will ensure that the final version of the environmental review document describes the results of any coordination with and comments made by TCEQ.

Section 2.306 explains that TCEQ will provide publicly available information to TxDOT related to air quality so that TxDOT may incorporate such information into its analyses of how a project may impact air resources.

Section 2.307 states that TCEQ reserves all rights it has to enforce relevant laws and that the parties intend that TCEQ's participation in this MOU does not have the effect of waiving those rights or the requirements of any laws that apply to the projects covered by the MOU. Also, the parties agree that the MOU does not preclude either party from making any legal argument.

Section 2.308 expresses the intent of TxDOT and TCEQ to update the MOU in the future as required by Transportation Code, §201.607, or as necessitated by a change in state and federal law or a change in the state implementation plan.

FISCAL NOTE

James Bass, Chief Financial Officer, has determined that for each year of the first five years in which the repeal and new subchapter as proposed are in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the repeal and new subchapter.

Carlos Swonke has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the repeal and new subchapter.

PUBLIC BENEFIT AND COST

Mr. Swonke has also determined that for each year of the first five years in which the repeal and new subchapter are in effect, the public benefit anticipated as a result of enforcing or administering the repeal and new subchapter will be increased efficiency in completing the environmental review of the department's projects, and more effective coordination with TCEQ on the department's projects. There are no anticipated economic costs for persons required to comply with the repeal and new subchapter as proposed. There will be no adverse economic effect on small businesses.

TAKINGS IMPACT ASSESSMENT

The department has evaluated this proposed repeal and new rules to determine whether Government Code, Chapter 2007 (Private Real Property Rights Preservation Act) requires the department to complete a takings assessment. The department has determined that the proposed repeal and new rules does

not affect private real property in a manner that requires the takings assessment.

COASTAL MANAGEMENT PROGRAM CONSISTENCY REVIEW

The department determined that this rulemaking relates to actions subject to the Texas Coastal Management Program (CMP) under the Coastal Coordination Act of 1991, as amended (Natural Resources Code, §§33.201 et seq.) and must be consistent with all applicable CMP policies, because it concerns the department's environmental review of transportation projects. The department reviewed this action for consistency with the CMP goals and policies under the rules promulgated by the Coastal Coordination Council, which remain in effect until superseded by rules of the General Land Office. The department has determined that the action is consistent with applicable CMP goals and policies.

A CMP policy applicable to this rulemaking is that transportation projects shall comply with certain practices concerning the siting of a project to lessen the impacts on coastal natural resources (see 31 TAC §501.31). The proposed rules concern the method by which to evaluate the environmental impacts of a transportation project and do not dictate the siting of a project. However, the purpose of the proposed rules is to establish procedures for identifying the impacts of transportation projects on certain resources, and for coordination of projects with the relevant state resource agency. This provides an additional mechanism for avoiding, minimizing, or mitigating, where practicable, adverse effects of department projects on coastal natural resource areas that serve as habitat, on coastal preserves, and on threatened and endangered species. For these reasons, the rulemaking action is consistent with the CMP goal of protecting, preserving, restoring, and enhancing the diversity, quality, quantity, functions, and values of coastal natural areas.

A copy of this rulemaking will be submitted to the General Land Office for its comments on the consistency of the proposed rulemaking with the CMP. The department requests that the public also give comment on whether the proposed rulemaking is consistent with the CMP.

PUBLIC HEARING

Pursuant to the Administrative Procedure Act, Government Code, Chapter 2001, the Texas Department of Transportation will conduct a public hearing to receive comments concerning the proposed repeal and new rules. The public hearing will be held at 1:30 p.m. on Thursday, March 7, 2013, in the Ric Williamson Hearing Room, First Floor, Dewitt C. Greer State Highway Building, 125 East 11th Street, Austin, Texas and will be conducted in accordance with the procedures specified in 43 TAC §1.5. Those desiring to make comments or presentations may register starting at 1:00 p.m. Any interested persons may appear and offer comments, either orally or in writing; however, questioning of those making presentations will be reserved exclusively to the presiding officer as may be necessary to ensure a complete record. While any person with pertinent comments will be granted an opportunity to present them during the course of the hearing, the presiding officer reserves the right to restrict testimony in terms of time and repetitive content. Organizations, associations, or groups are encouraged to present their commonly held views and identical or similar comments through a representative member when possible. Comments on the proposed text should include appropriate citations to sections, subsections, paragraphs, etc. for proper reference. Any suggestions or requests for alternative language or other revisions to the proposed text should be submitted in written form. Presentations must remain pertinent to the issues being discussed. A person may not assign a portion of his or her time to another speaker. Persons with disabilities who plan to attend this meeting and who may need auxiliary aids or services such as interpreters for persons who are deaf or hearing impaired, readers, large print or Braille, are requested to contact Government and Public Affairs Division, 125 East 11th Street, Austin, Texas 78701-2483, (512) 463-6086 at least five working days prior to the hearing so that appropriate services can be provided.

SUBMITTAL OF COMMENTS

Written comments on the proposed repeal of §2.23 and new Subchapter I, §§2.301 - 2.308 may be submitted to Robin Carter, Office of General Counsel, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78701-2483 or to RuleComments@txdot.gov with the subject line "TCEQ MOU." The deadline for receipt of comments is 5:00 p.m. on March 18, 2013. In accordance with Transportation Code, §201.811(a)(5), a person who submits comments must disclose, in writing with the comments, whether the person does business with the department, may benefit monetarily from the proposed rules, or is an employee of the department.

SUBCHAPTER B. MEMORANDA OF UNDERSTANDING WITH NATURAL RESOURCE AGENCIES

43 TAC §2.23

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Department of Transportation or in the Texas Register office, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

STATUTORY AUTHORITY

The repeal is proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §201.607(b), which requires the department to adopt memoranda of understanding with each agency that has responsibility for the protection of the natural environment or for the preservation of historical or archeological resources, and to adopt all revisions to these memoranda by rule.

CROSS REFERENCE TO STATUTE

Transportation Code, §201.607.

§2.23. Memorandum of Understanding with the Texas Natural Resource Conservation Commission.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300411

Jeff Graham
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 463-8683

♦ ♦ ♦

SUBCHAPTER I. MEMORANDUM OF UNDERSTANDING WITH THE TEXAS COMMISSION ON ENVIRONMENTAL QUALITY

43 TAC §§2.301 - 2.308

STATUTORY AUTHORITY

The new sections are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §201.607(b), which requires the department to adopt memoranda of understanding with each agency that has responsibility for the protection of the natural environment or for the preservation of historical or archeological resources, and to adopt all revisions to these memoranda by rule.

CROSS REFERENCE TO STATUTE

Transportation Code, §201.607.

§2.301. Purpose.

This subchapter contains the Memorandum of Understanding (MOU) between the Texas Department of Transportation (TxDOT) and the Texas Commission on Environmental Quality (TCEQ) concerning the review of the potential environmental effect of transportation projects as required by Transportation Code, §201.607. The MOU does not affect coordination or permits required by other state or federal laws; however, as set forth in this MOU, TxDOT may elect to coordinate with TCEQ under this MOU concerning transportation projects that this MOU does not require to be coordinated. The purpose of this MOU is to provide a formal mechanism by which TCEQ reviews transportation projects that have the potential to affect resources within TCEQ's jurisdiction. This MOU also promotes the mutually beneficial sharing of information between TxDOT and TCEQ, which will assist TxDOT in making environmentally sound decisions.

§2.302. Authority.

(a) Transportation Code, §201.607, directs the Texas Department of Transportation to adopt memoranda of understanding with each agency that has responsibilities for the protection of the natural environment.

(b) Under Water Code, §5.104(b) and Health and Safety Code, §382.035, the Texas Commission on Environmental Quality (TCEQ) may enter into a memorandum of understanding with any other state agency and shall adopt by rule any memorandum of understanding between TCEQ and any other state agency.

§2.303. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Assessment unit--For a water body in the state, the smallest geographic area of use support analyzed for such body in Texas Commission on Environmental Quality's most recent integrated report prepared under the Clean Water Act §305(b) that includes a Clean Water Act §303(d) list that has been approved by the U.S. Environmental Protection Agency. An assessment unit is based on the primary segment assessment unit identified in the integrated report.

(2) Construction--Activities that involve the building of transportation projects on new location; or the expansion, rehabilitation, or reconstruction, of an existing facility.

(3) EPA--The United States Environmental Protection Agency.

(4) Environmental report--A report, form, checklist, or other documentation analyzing an environmental issue in the context of a specific transportation project or presenting a thorough summary of an environmental study conducted in support of an environmental review document, or demonstrating compliance with a specific environmental requirement. The term does not include a permit or other approval outside the scope of the environmental review process.

(5) Environmental review document--An environmental assessment, a draft environmental impact statement, a final environmental impact statement, a reevaluation as described in §2.85 of this chapter (relating to Reevaluations), or a supplemental environmental impact statement as described in §2.86 of this chapter (relating to Supplemental Environmental Impact Statements), or a document prepared to demonstrate that an Federal Highway Administration (FHWA) transportation project qualifies as a categorical exclusion when FHWA requires a narrative document as opposed to a checklist. An environmental review document includes any attached environmental reports.

(6) Federal Clean Air Act (FCAA)--The federal statute, including all amendments, that establishes National Ambient Air Quality Standards (NAAQS) and mandates procedures for reaching and maintaining these standards, codified at 42 United States Code §§7401, et seq.

(7) FHWA transportation project--A transportation project for which the approval of the United States Department of Transportation Federal Highway Administration (FHWA) is required by law to comply with the National Environmental Policy Act, codified at 42 United States Code §§4321, et seq. and implementing regulations (NEPA), FHWA is the lead federal agency, and FHWA agrees Texas Department of Transportation may act as the joint lead agency under 23 Code of Federal Regulations §771.109.

(8) Impaired assessment unit--An assessment unit that does not support or meet water quality standards established by the Texas Commission on Environmental Quality (TCEQ) as shown in TCEQ's most recent integrated report prepared under the Clean Water Act §305(b) that includes a Clean Water Act §303(d) list that has been approved by EPA. An assessment unit identified in the integrated report as impaired due to nonsupport of a water quality standard that is not caused by a pollutant (identified as category 4c) will not be considered an impaired assessment unit for the purposes of this MOU.

(9) Maintain or maintenance--Activities which involve the upkeep or preservation of an existing facility to prevent that facility's degradation to an unsafe or irreparable state, or which involve the treatment of an existing facility or its environs to meet acceptable standards of operation or aesthetic quality. The activities generally do not require the acquisition of additional right of way or result in increased roadway capacity.

(10) Maintenance area--A geographic area previously designated as a non-attainment area and subsequently redesignated to attainment subject to the requirement to develop a maintenance plan under 42 United States Code §7505a of the FCAA, and other areas designated as maintenance areas by the EPA.

(11) Non-attainment area--A geographic area designated nonattainment by the EPA as failing to meet the NAAQS for a pollutant for which a standard exists. The EPA designates counties (or portions thereof) as nonattainment under the provisions of 42 United States Code §7407(d). For the official list and boundaries of nonattainment areas, see 40 Code of Federal Regulations Part 81 and relevant notices in the *Federal Register*.

(12) State Implementation Plan (SIP)--The plan prepared by the TCEQ under 42 United States Code §7410 of the FCAA to attain, maintain, implement, or enforce NAAQS. An approved SIP is the implementation plan, or most recent revision of this plan, that has been approved by EPA under 42 United States Code §7410 of the FCAA.

(13) TCEQ--Texas Commission on Environmental Quality.

(14) TxDOT--Texas Department of Transportation.

(15) Total Maximum Daily Load (TMDL)--The total amount of a substance that a water body can assimilate and still meet the Texas Surface Water Quality Standards as adopted by the TCEQ for a particular water body.

(16) TMDL Implementation Plan (I-Plan)--A plan describing the strategy and activities TCEQ and watershed partners will carry out to improve water quality in the affected watershed.

(17) Transportation enhancement--An activity that is listed under 23 United States Code §101(a)(29), that relates to a transportation project, and is eligible for federal funding under 23 United States Code §133.

(18) Transportation project--A project to construct, maintain, or improve a highway, rest area, toll facility, aviation facility, public transportation facility, rail facility, ferry, or ferry landing. A transportation enhancement is also a transportation project.

§2.304. Responsibilities.

(a) TxDOT is responsible for the development, construction, maintenance, and operation of the state highway system and other transportation systems as designated by the legislature.

(b) TCEQ is the state air and water pollution control agency and is the principal authority in Texas on matters relating to the quality of the state's air and water resources, including the following:

(1) Air quality. TCEQ's primary responsibility relating to air, as designated by Health and Safety Code, §382.002, includes, but is not limited to, setting standards, criteria, levels, and emission limits for air quality and air pollution control; and

(2) Water quality. TCEQ is charged with the protection of water quality, water rights, and the adoption and enforcement of rules and performance of other acts relating to the safe construction, maintenance, and removal of dams. TCEQ's jurisdiction over water quality, water rights, and enforcement of both water quality and water rights includes, but is not limited to, those items outlined in Water Code, §5.013.

§2.305. Coordination during Environmental Review Process.

(a) Applicability. This section specifies when TxDOT shall designate TCEQ as a participating agency in relation to the environmental review of a transportation project, and therefore coordinate with TCEQ. TxDOT may elect to coordinate with TCEQ concerning other transportation projects that this MOU does not require to be coordinated.

(1) Not applicable. This MOU does not apply to a project that TxDOT classifies as a categorical exclusion, blanket categorical exclusion, or programmatic categorical exclusion, under §2.81 of this chapter (relating to Categorical Exclusions) or §2.82 of this chapter (relating to Blanket and Programmatic Categorical Exclusions), and TxDOT will not coordinate such projects with TCEQ.

(2) Applicable.

(A) Environmental reports. TxDOT may, but is not required to, separately coordinate an environmental report with TCEQ.

(B) Environmental assessments. TxDOT shall coordinate the environmental assessment with TCEQ if one or more of the triggers in subsection (b) of this section apply, except TxDOT will not coordinate an environmental assessment if:

(i) TxDOT already coordinated one or more environmental reports for a project that evaluate the subject matter of all applicable triggers in subsection (b) of this section;

(ii) the project as it affects the subject matter of the applicable triggers in subsection (b) of this section does not subsequently change;

(iii) the conclusions in the environmental reports do not subsequently change; and

(iv) TCEQ did not request TxDOT to also coordinate the environmental assessment under subsection (d)(2) of this section.

(C) Environmental impact statements and supplemental environmental impact statements. TxDOT shall coordinate the draft environmental impact statement and the final environmental impact statement with TCEQ following the requirements of this MOU and at the times described in §2.103(d)(2)(A) and (B) and (g)(2) of this chapter (relating to Public Participation for an Environmental Impact Statement or Supplemental Environmental Impact Statement). TxDOT will coordinate a supplemental environmental impact statement with TCEQ following the requirements of this MOU.

(D) Reevaluations. If TxDOT prepares a written reevaluation for a transportation project under §2.85 of this chapter (relating to Reevaluations), TxDOT shall coordinate the reevaluation with TCEQ if the earlier coordination concerning the project is no longer valid as a result of changes in the project.

(b) Triggers for coordination.

(1) Air quality. Projects that add capacity in a nonattainment or maintenance area of the State.

(2) Water quality.

(A) Projects that will require Tier II individual Clean Water Act Section 401 certification under procedures defined in the most recent version of the memorandum of agreement between the U.S. Army Corps of Engineers and TCEQ.

(B) Projects located in the recharge, transition, or contributing zones of the Edwards Aquifer, pursuant to 30 TAC Chapter 213, Subchapters A and B (relating to Edwards Aquifer). For these projects, the environmental review document or environmental report provided to TCEQ by TxDOT shall provide the location of the project within the Edwards Aquifer. TxDOT shall include a statement that the proposed projects and associated activities are to be implemented, operated, and maintained in a manner that complies with the Edwards Aquifer rules and any applicable TCEQ guidance documents in effect to implement the rules.

(C) Projects located within five miles of an impaired assessment unit and within the watershed of the impaired assessment unit.

(i) Determination of trigger. For the purposes of this subparagraph, the determination of whether an assessment unit is impaired must be made when TxDOT assesses whether a trigger in this subparagraph applies to the transportation project, and must be based on the most recent TCEQ integrated report at that time prepared under Clean Water Act §305(b) that includes a Clean Water Act §303(d) list that has been approved by the EPA.

(I) TxDOT will identify impaired assessment units using information publicly available from TCEQ.

(II) TxDOT shall identify whether the project drains to any impaired assessment unit using publicly available map resources, survey data, topographic data, or other scientifically valid data. TxDOT may identify the watershed of an impaired assessment unit using the 12-digit hydrologic unit codes produced by the United States Geologic Service.

(ii) Required information. If the trigger in this subparagraph applies to a project, TxDOT in the environmental review document or environmental report shall provide the location of the project in the watershed of the impaired assessment unit, the assessment unit number, segment name, segment number, impairments, and the year of the Clean Water Act §303(d) list used, and shall provide:

(I) For impaired assessment units with EPA-approved TMDLs, the name and date of the EPA-approved TMDL and if applicable, the TCEQ-approved I-Plan, and a statement that the project and associated activities will be implemented, operated, and maintained in a manner that is consistent with the approved TMDL or approved I-Plan; or

(II) For impaired assessment units without EPA-approved TMDLs, an acknowledgement that the assessment unit does not have an EPA-approved TMDL and a statement that the project and associated activities will be implemented, operated, and maintained using best management practices to control the discharge of pollutants from the project site.

(c) General.

(1) No coordination by local government. When a local government acts as the project sponsor concerning the preparation of an environmental review document or environmental report, TxDOT shall perform the coordination of the document with TCEQ as described in this MOU.

(2) Compliance with law. Environmental review documents and environmental reports prepared and provided to TCEQ by TxDOT will be in compliance with applicable law.

(3) Computation of time. In computing time for the purposes of this MOU, the period begins on the day after the act or event in question and concludes at the end of the last day of that designated period, unless that day is a Saturday, Sunday, or state holiday, in which event the period concludes at the end of the next day that is not a Saturday, Sunday, or state holiday.

(d) Review and response.

(1) TxDOT shall forward the environmental review document or environmental report to the e-mail address specified by TCEQ. The e-mail will indicate all triggers under subsection (b) of this section that apply to the project. TCEQ shall have a period of 30 days, from the date of receipt, to review the environmental review document or environmental report and provide written comments. Before the deadline for review, TCEQ may, if necessary, notify TxDOT that it is extending the review period for no more than 15 additional days. TCEQ will submit any comments to the e-mail address specified by TxDOT.

(2) For a project for which TxDOT prepares an environmental assessment, if TxDOT coordinates an environmental report concerning the project, TCEQ may request during the comment period that TxDOT also coordinate the environmental assessment for the project. If TCEQ makes a request TxDOT shall coordinate the related environmental assessment.

(3) If TCEQ provides comments, TxDOT will respond in writing to TCEQ's comments. TxDOT will ensure that the final version of the environmental review document describes the results of any coordination with and comments made by TCEQ, and includes a summary of those contacts and comments. TxDOT will consider TCEQ comments submitted to TxDOT after the comment deadline to the extent possible, given the stage of the environmental review process at the time of the submission.

§2.306. Exchange of Air Quality Information.

(a) Upon request by TxDOT, TCEQ will provide publicly available information to TxDOT related to air quality, such as:

(1) information useful for establishing existing air quality conditions to be described in an environmental review document;

(2) the location and severity of conditions in non-attainment areas;

(3) information affecting transportation-related activity and mobile sources in the state implementation plan; and

(4) proposed and existing locations of roadside air monitors.

(b) TxDOT and TCEQ will exchange data useful for developing mobile source budgets, and data on transportation conformity determinations, including for any area newly designated by EPA as a non-attainment area.

§2.307. No Waiver of Rights.

As the state environmental regulatory agency, TCEQ reserves all rights it has to enforce relevant laws, and the parties intend that TCEQ's participation in this MOU does not have the effect of waiving those rights or the requirements of any laws that apply to the projects covered by this MOU. The parties agree that this MOU does not preclude either party from making any legal argument.

§2.308. Review of MOU.

This MOU shall be reviewed and updated no later than January 1, 2017. TxDOT and TCEQ by rule shall adopt the MOU and all revisions to the MOU. If a change in state or federal law or a change in the SIP necessitates a change in this MOU, then representatives from both TxDOT and TCEQ will meet to work out a mutually agreeable amendment to the MOU.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300412
Jeff Graham
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 463-8683

♦ ♦ ♦

CHAPTER 2. ENVIRONMENTAL REVIEW OF TRANSPORTATION PROJECTS

The Texas Department of Transportation (department) proposes the repeal of §2.24, concerning Memorandum of Understanding with the Texas Historical Commission. The department proposes the simultaneous replacement of the repealed section with new Subchapter H, §§2.251 - 2.278, concerning Memorandum of Understanding with the Texas Historical Commission.

EXPLANATION OF PROPOSED REPEAL AND NEW SECTIONS

Transportation Code, §201.607 requires the department to adopt a memorandum of understanding (MOU) with each state agency that has responsibilities for the protection of the natural environment or for the preservation of historic or archeological resources. Transportation Code, §201.607 also requires the department to adopt the MOU and all revisions to it by rule and to periodically evaluate and revise the MOU. In order to meet the legislative intent and to ensure that historic and archeological resources are given full consideration in accomplishing the department's activities, the department has evaluated its MOU with the Texas Historical Commission (THC) adopted in 2004, and finds it necessary to repeal existing §2.24 and simultaneously propose new Subchapter H, §§2.251 - 2.278.

The proposed new MOU between THC and the department satisfies the statutory requirements for reviewing and revising MOUs with resource agencies. It is intended to replace the existing MOU, which has been in effect since May 20, 2004, with an MOU that more effectively streamlines THC's review of the department's projects and simultaneously better allows THC to focus on those projects most likely to affect historic or archeological resources. The proposed MOU has several new provisions and procedures that were developed based on experience gained from numerous projects that the department has submitted and THC has reviewed since the 2004 MOU was executed. It is also better organized than the existing MOU, with different subject areas broken into separate sections. Additionally, the proposed MOU reflects changes made by the department's recent revision of its environmental review rules, published in the March 9, 2012, issue of the *Texas Register* (37 TexReg 1727).

SECTION BY SECTION EXPLANATION OF PROPOSED MOU

Section 2.251 sets out the purpose of the MOU, identifies the statutory provisions under which the MOU is adopted, and explains that the MOU supersedes the 2004 MOU.

Section 2.252 sets forth the applicability of the MOU by explaining that it applies to any transportation project for which an environmental review is performed under the department's environmental review rules, and any other project coordinated at the department's request. Whether coordination for a given project is required under the MOU is addressed in §2.255, concerning Coordination Responsibilities, §2.257, concerning Projects Excluded from Review for Archeology Resources and Cemeteries, and §2.270, concerning Projects Excluded from Review for Non-Archeological Historic Properties. Section 2.252 also clarifies that federally funded, licensed, or permitted projects may follow the procedures set forth in the MOU only if doing so would not conflict with the lead federal agency's environmental rules.

Section 2.253 explains that, for federally funded projects, the terms of a programmatic agreement among the department, the Federal Highway Administration, the Texas State Historic Preservation Officer, and the Advisory Council on Historic Preservation, if applicable, will control rather than terms of the MOU. The section also obligates the department and THC to seek to revise the existing programmatic agreement to reflect the procedures of the MOU.

Section 2.254 contains definitions of various terms used in the MOU.

Section 2.255 sets forth the department's and THC's coordination responsibilities under the MOU. It explains that the department shall coordinate with THC on all transportation projects for which the department is the project sponsor under 43 TAC §2.7 unless the project is of a type that is exempt from coordination under another section of the MOU. Section 2.255 also specifies that coordination required by the MOU must be conducted by or through the department's Environmental Affairs Division, unless otherwise agreed to by THC. The section also clarifies that coordination of work in department right-of-way associated with a project for which the department is not the project sponsor under 43 TAC §2.7 is the responsibility of the project sponsor, and not the department, unless the department and THC agree that the department will coordinate the project. Finally, the section generally describes THC's coordination responsibilities under the MOU, such as to conduct any required review in an efficient manner.

Section 2.256 sets parameters on staff qualifications and the use of consultants for cultural resource investigations undertaken in accordance with the MOU. For example, all staff conducting such an investigation must meet certain professional standards detailed in the section.

Section 2.257 exempts certain types of routine projects from the requirement to conduct a project-specific review for impacts to archeological resources or cemeteries. Examples of exempt project types include installation, repair, or replacement of fencing, resurfacing, and replacement, upgrade, or repair of safety barriers. The section further explains that project types exempted from review under the MOU are also exempt from other THC rules regarding project-specific investigations or coordination for potential impacts to cemeteries, unless certain conditions are present.

Section 2.258 sets forth the procedures for project coordination when review for archeological resources and cemeteries is required. If, after conducting an evaluation of the area for potential effects for a given project, the department determines that the project will not affect archeological historic properties and that the area of potential effects contains no cemeteries, the department may approve the project to proceed to construction without review by THC. The department must submit to THC a quarterly report of projects so evaluated and internally approved.

If the department determines that a given project may affect archeological historic properties or that the area of potential effects contains a cemetery, the department must submit to the THC a request for review of the project. Section 2.258 explains the different types of findings, determinations, and recommendations that the department must include in its request for review. If the project will have an adverse effect on an archeological historic property or cemetery within the area of potential effects, the department must recommend to THC appropriate means by which to resolve the potential adverse effect. The section specifies the various forms the resolution of adverse effects may take, and prescribes various requirements for cases in which data recovery is the selected means for resolving adverse effects. Fi-

nally, §2.258 sets parameters on when and how THC must respond to a request for review submitted by the department.

Section 2.259 contains provisions governing the department's investigations of a projects' area of potential effects, including provisions for determining when field investigations are required, and when background information such as maps and project-area photographs may be used.

Section 2.260 sets forth procedures for THC's issuance of antiquities permits to the department. Under these procedures, the department is not required to submit an antiquities permit application provided that certain conditions are satisfied, such as that the department provides THC with notification of the work, and that the work is overseen by the archeological staff of the department's Environmental Affairs Division. The section also includes provisions allowing the department to initiate work under an emergency permit when conditions of natural disasters, man-made disasters, or post-review discovery necessitate immediate action. Provisions governing the department's work under permits issued by THC, such as provisions explaining when work under a permit will be considered complete, are also included in §2.260.

Section 2.261 contains provisions governing the department's conduct of surveys to investigate archeological resources and cemeteries. For example, the section explains that subsurface investigation is not required where it can be demonstrated that the portion of the site to be affected is not likely to have sufficient integrity to be eligible for designation as a State Antiquities Landmark.

Section 2.262 prescribes methods to be used by the department when conducting test excavations. The section allows the department to depart from the specified methods in cases where it is deemed appropriate, but requires the department to justify deviations in the resulting written report. Section 2.262 also requires data from test excavation projects to be made available to qualified researchers.

Section 2.263 requires the department, under certain conditions, to develop public educational outreach projects for significant data recovery investigations. Section 2.263 requires data from data recovery projects to be made available to qualified researchers.

Section 2.264 concerns exhumation, which is a form of investigation to resolve a project's adverse effects on a cemetery. The section explains when exhumation efforts may begin, and identifies tasks that represent a sufficient, reasonable, and good faith effort to identify remains and any next of kin associated with burials in unknown or abandoned cemeteries.

Section 2.265 prescribes the procedures the department must follow when it discovers an archeological site discovered after it has awarded a construction contract. The department must immediately suspend construction or any other activities that would affect the site, and perform various specified tasks before resuming.

Section 2.266 concerns standard treatments for particular resource types. It sets forth standards to be followed by the department when encountering isolated wells or cisterns unassociated with other remains, or burnt rock midden features that have not been obviously destroyed by modern disturbances.

Section 2.267 sets standards for the department's recovery and curation of artifacts. For example, while the department may temporarily house artifacts and samples during laboratory analysis and research, it must transfer them to a permanent curatorial facility upon completion of the analysis.

Section 2.268 establishes minimum documentation requirements for projects subject to review for archeological resources and cemeteries under the MOU.

Section 2.269 requires the department to submit to THC quarterly reports listing all projects for which the department documented that no historic properties are present in the area of potential effects, or that the project will have no adverse effects on archeological historic properties or cemeteries.

Section 2.270 pertains to review for impacts to non-archeological historic properties. It lists a number of project types that pose limited potential to affect historic properties, and provides that, for listed project types, if qualified department staff determine that no evaluation of a given project is needed, then none is required under the MOU or under other THC rules.

Section 2.271 explains the procedure for review of a project for impacts to non-archeological historic properties when an evaluation is required. The section sets forth two different levels of review: internal review and coordinated review. For a project subject to review for impacts to non-archeological historic resources, if department personnel determine that the project will have no effect or no adverse effect on historic properties, then only internal review is required. Such a project is required to be recorded on a quarterly report.

If a project is determined by department personnel to have an adverse effect on a historic property, then coordinated review is required. Under the §2.271 procedures, THC must respond within 20 calendar days of the department's request for review by indicating whether an affected historic property will require a historic structures permit, or whether THC intends to initiate a State Antiquities Landmark nomination for the affected property. If THC does not respond within 20 days, the department may assume THC's concurrence with its determinations, and proceed with construction of the project. Section 2.271 also contains provisions governing notification of work affecting a county courthouse, projects that may subsequently require a federal permit or change to federal funding and that involve a direct taking of an historic property, and required documentation both for projects internally reviewed and for projects for which coordinated review is conducted.

Section 2.272 explains that, in cases in which the department cannot gain access to private land needed to complete an investigation under the MOU prior to approval of the environmental review document, it must complete the investigation once access is obtained, but prior to any construction-related impacts.

Section 2.273 provides that if the department utilizes the procedures set forth in the MOU, then it will be considered to be in compliance with any other applicable THC requirements. In other words, with respect to department projects, the terms of the MOU control over THC's generally applicable rule requirements.

Section 2.274 specifies that any project-specific agreements reached between the department and THC will supersede the requirements of the MOU.

Section 2.275 obligates the department and THC to collaborate on improvements to their programs and development of innovative solutions for expedited review procedures, such as using project outcomes to refine approaches to resource identification, evaluation, treatment methods, programmatic mitigation

measures and interagency agreements that facilitate early coordination, streamlining, and expedited review of the department's transportation projects.

Section 2.276 allows THC to review department project files for specific undertakings carried out under the MOU, and recommend process improvements based on issues identified during the review.

Section 2.277 provides that THC and department staff will be responsible for attempting to resolve any conflict between THC and the department that results from the implementation of this subchapter before elevating to agency management.

Section 2.278 provides that THC and the department will convene every four years to review, update, or extend this agreement. This review cycle is shorter than the five-year review cycle prescribed by Transportation Code, §201.607(a).

FISCAL NOTE

James Bass, Chief Financial Officer, has determined that for each year of the first five years in which the proposed repeal and new subchapter are in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the repeal and new subchapter.

Carlos Swonke has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the repeal and new subchapter.

PUBLIC BENEFIT AND COST

Mr. Swonke has also determined that for each year of the first five years in which the repeal and new subchapter are in effect, the public benefit anticipated as a result of enforcing or administering the repeal and new subchapter will be increased efficiency in completing the environmental review of the department's projects, and more effective coordination with THC on the department's projects. There are no anticipated economic costs for persons required to comply with the sections as proposed. There will be no adverse economic effect on small businesses.

COASTAL MANAGEMENT PROGRAM CONSISTENCY REVIEW

The department determined that this rulemaking relates to actions subject to the Texas Coastal Management Program (CMP) under the Coastal Coordination Act of 1991, as amended (Natural Resources Code, §§33.201 et seq.) and must be consistent with all applicable CMP policies, because it concerns the department's environmental review of transportation projects.

The department reviewed this action for consistency with the CMP goals and policies under the rules promulgated by the Coastal Coordination Council, which remain in effect until superseded by rules of the General Land Office. Because this MOU relates to review of impacts to historic or archeological resources, rather than impacts to natural resources, the department has not identified any CMP goals and policies applicable to this MOU.

A copy of this rulemaking will be submitted to the General Land Office for its comments on the consistency of the proposed rulemaking with the CMP. The department requests that the public also give comment on whether the proposed rulemaking is consistent with the CMP.

PUBLIC HEARING

Pursuant to the Administrative Procedure Act, Government Code, Chapter 2001, the Texas Department of Transportation will conduct a public hearing to receive comments concerning the proposed repeal and new rules. The public hearing will be held at 1:30 p.m. on Thursday, March 7, 2013, in the Ric Williamson Hearing Room, First Floor, Dewitt C. Greer State Highway Building, 125 East 11th Street, Austin, Texas and will be conducted in accordance with the procedures specified in 43 TAC §1.5. Those desiring to make comments or presentations may register starting at 1:00 p.m. Any interested persons may appear and offer comments, either orally or in writing; however, questioning of those making presentations will be reserved exclusively to the presiding officer as may be necessary to ensure a complete record. While any person with pertinent comments will be granted an opportunity to present them during the course of the hearing, the presiding officer reserves the right to restrict testimony in terms of time and repetitive content. Organizations, associations, or groups are encouraged to present their commonly held views and identical or similar comments through a representative member when possible. Comments on the proposed text should include appropriate citations to sections, subsections, paragraphs, etc. for proper reference. Any suggestions or requests for alternative language or other revisions to the proposed text should be submitted in written form. Presentations must remain pertinent to the issues being discussed. A person may not assign a portion of his or her time to another speaker. Persons with disabilities who plan to attend this meeting and who may need auxiliary aids or services such as interpreters for persons who are deaf or hearing impaired, readers, large print or Braille, are requested to contact Government and Public Affairs Division, 125 East 11th Street, Austin, Texas 78701-2483, (512) 463-6086 at least five working days prior to the hearing so that appropriate services can be provided.

SUBMITTAL OF COMMENTS

Written comments on the proposed repeal of §2.24 and new Subchapter H, §§2.251 - 2.278 may be submitted to Robin Carter, Office of General Counsel, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78701-2483 or to RuleComments@txdot.gov with the subject line "THC MOU." The deadline for receipt of comments is 5:00 p.m. on March 18, 2013. In accordance with Transportation Code, §201.811(a)(5), a person who submits comments must disclose, in writing with the comments, whether the person does business with the department, may benefit monetarily from the proposed rules, or is an employee of the department.

SUBCHAPTER B. MEMORANDA OF UNDERSTANDING WITH NATURAL RESOURCE AGENCIES

43 TAC §2.24

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Department of Transportation or in the Texas Register office, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

STATUTORY AUTHORITY

The repeal is proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §201.607(b), which requires the department to adopt memo-

randa of understanding with each agency that has responsibility for the protection of the natural environment or for the preservation of historical or archeological resources, and to adopt all revisions to these memoranda by rule.

CROSS REFERENCE TO STATUTE

Transportation Code, §201.607.

§2.24. Memorandum of Understanding with the Texas Historical Commission.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300409
Jeff Graham
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 463-8683

♦ ♦ ♦

SUBCHAPTER H. MEMORANDUM OF UNDERSTANDING WITH THE TEXAS HISTORICAL COMMISSION

43 TAC §§2.251 - 2.278

STATUTORY AUTHORITY

The new sections are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §201.607(b), which requires the department to adopt memoranda of understanding with each agency that has responsibility for the protection of the natural environment or for the preservation of historical or archeological resources, and to adopt all revisions to these memoranda by rule.

CROSS REFERENCE TO STATUTE

Transportation Code, §201.607.

§2.251. Purpose and Authority.

This subchapter contains the memorandum of understanding (MOU) entered into by the Texas Historical Commission (THC) and the Texas Department of Transportation (TxDOT) in accordance with Government Code, §442.005 and §442.007; Natural Resources Code, §191.0525(f); and Transportation Code, §201.607. The purpose of this MOU is to provide a formal mechanism for expediting THC review of TxDOT's transportation projects that potentially pose adverse effects on cultural resources. This MOU supersedes the previous MOU made effective on May 20, 2004.

§2.252. Applicability.

(a) Except as provided in subsection (b) of this section, this subchapter generally applies to:

(1) a transportation project for which an environmental review is being or will be performed under this chapter; or

(2) any other type of project coordinated at TxDOT's request.

(b) Federally funded, licensed, or permitted projects may follow the procedures of this subchapter only if doing so would not conflict with environmental rules promulgated by the lead federal agency.

§2.253. Programmatic Agreements.

(a) Provisions of this MOU may be implemented, in part, through a Programmatic Agreement (PA) among the Federal Highway Administration (FHWA), the Texas State Historic Preservation Officer (TSHPO), the Advisory Council on Historic Preservation (Council), and TxDOT.

(b) With respect to federally funded projects, instead of the procedures set forth in this MOU, THC and TxDOT shall use the applicable procedures outlined in their First Amended Programmatic Agreement Among the Federal Highway Administration, the Texas Department of Transportation, the Texas State Historic Preservation Officer, and the Advisory Council on Historic Preservation Regarding the Implementation of Transportation Undertakings (PA-TU) and its successors to provide for innovation and efficiency in the timely development of TxDOT's transportation projects considerate of their impacts on cultural resources.

(c) TxDOT and THC will seek to revise the existing PA, amended in 2005, to reflect the streamlined procedures contained in this MOU.

§2.254. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Antiquities permit--A permit issued by the Texas Historical Commission in order to regulate the taking, alteration, damage, exhumation, destruction, salvage, archeological survey, testing, excavation and study of state antiquities landmarks including prehistoric and historic archeological sites, and the preservation, protection, stabilization, conservation, rehabilitation, restoration, reconstruction, or demolition of historic structures and buildings designated as a State Antiquities Landmark (or listed in the National Register of Historic Places).

(2) Area of potential effects (APE)--The geographic space or spaces within which an undertaking may cause changes in the character or use of historic properties, if any such properties exist.

(A) The area of potential effects for archeological properties will be confined to the limits of the proposed project right of way (including permanent and temporary easements), utility relocations designated by TxDOT, and project-specific locations designated by TxDOT. The area of potential effects also extends to the depth of impacts caused by the undertaking.

(B) The area of potential effects for non-archeological historic properties for all non-federal undertakings will be confined to the limits of the proposed project right of way (including permanent and temporary easements), utility relocations, and project-specific locations specifically designated by TxDOT.

(3) Cultural resources--A general term referring to buildings, structures, shipwrecks, objects, sites, and districts more than 50 years of age with the potential to have significance in local, state, or national history.

(4) Effect--Alteration to the characteristics of a historic property qualifying it for formal designation as a State Antiquities Landmark.

(5) Eligibility--A property's eligibility for designation as a State Antiquities Landmark, as set forth in 13 TAC Chapter 26 (relating to Practice and Procedure).

(6) Emergency permit--A permit that may be used by TxDOT under certain emergency circumstances for the purposes of performing investigations prior to formal application for an antiquities permit.

(7) Historic property--Any prehistoric or historic district, site, building, structure, or object that meets the requirements for designation as a State Antiquities Landmark as set forth in 13 TAC Chapter 26.

(8) Minor widening--Roadway projects resulting in pavement profile widened to less than double their original width, resulting from adding travel/center-turn lanes or paved shoulders.

(9) Project-specific location--The location of specific material sources (e.g., base material, borrow, and sand pits) and other sites used by a construction contractor for a specific project.

(10) State Antiquities Landmark (SAL)--Both Archeological and Non-archeological historic properties that are designated or eligible for designation as landmarks as defined in Subchapter D of the Antiquities Code of Texas (Natural Resources Code, Chapter 191) and identified in accordance with 13 TAC Chapter 26.

(11) THC--Texas Historical Commission.

(12) Transportation enhancement--An activity that is listed under 23 United States Code §101(a)(35), relates to a transportation project, and is eligible for federal funding under 23 United States Code §133.

(13) Transportation project--A project to construct, maintain or improve a highway, rest area, toll facility, aviation facility, public transportation facility, rail facility, ferry, or ferry landing. A transportation enhancement is also a transportation project.

(14) TxDOT--Texas Department of Transportation.

§2.255. Coordination Responsibilities.

(a) Texas Department of Transportation. The coordination responsibilities of TxDOT under this MOU are defined as follows.

(1) Except as provided in §2.257 of this subchapter (relating to Projects Excluded from Review for Archeology Resources and Cemeteries), §2.270 of this subchapter (relating to Projects Excluded from Review for Non-Archeological Historic Properties), or other provisions of this subchapter that exclude projects from coordination requirements, TxDOT shall coordinate review of transportation projects for which TxDOT is the project sponsor under §2.7 of this chapter (relating to Project Sponsor) with THC for both archeological resources and cemeteries, and non-archeological historic properties, as described in this MOU.

(2) All coordination required by this MOU shall be conducted by or through TxDOT's Environmental Affairs Division, or its successor as established by TxDOT administration, unless the division (or its successor) and THC agree in writing to allow other appropriate organizational units of TxDOT or other entities approved by the respective agencies to conduct the coordination.

(3) Work in TxDOT right-of-way that is not associated with a project for which TxDOT is the project sponsor under §2.7 of this chapter is the responsibility of the project sponsor and not of TxDOT (see Natural Resources Code, §191.0525), except as provided under paragraph (5) of this subsection. The project sponsor is responsible for coordinating directly with THC for such work, using the terms of this MOU to the extent THC determines appropriate. Examples of projects that will be coordinated by the non-TxDOT project sponsor directly with THC include but are not limited to:

(A) on-system highway projects funded entirely with local funds;

(B) utility relocations or installations within TxDOT right-of-way sponsored by other entities; and

(C) driveway and access connections sponsored by other entities.

(4) TxDOT shall not be a signatory to any permit issued by THC to another entity for work on a project funded or sponsored by such other entity.

(5) In accordance with §2.12(g)(1) of this chapter (relating to Project Coordination), TxDOT may coordinate projects sponsored or funded by another entity under this MOU by agreement with the non-TxDOT project sponsor, and TxDOT will provide notice to THC when it coordinates such projects.

(b) Texas Historical Commission. The coordination responsibilities of THC under this MOU are to conduct any review required by this subchapter in an efficient manner, to provide timely feedback to TxDOT about projects coordinated under this subchapter, and to apply any funding provided by TxDOT solely to the review of TxDOT's projects in a manner that most efficiently streamlines THC's effective review and early coordination.

§2.256. Qualifications of Staff and Use of Consultants.

(a) All cultural resource investigations executed under the terms of this MOU shall be implemented by staff who meet the requirements for professional personnel set forth in 13 TAC Chapter 26 (relating to Practice and Procedure) or the Secretary of the Interior's Professional Qualification Standards (36 C.F.R. Part 61, Appendix A).

(b) TxDOT has the right to perform cultural resource investigations using staff or consultants who meet the professional standards cited in subsection (a) of this section.

(c) Cultural resource surveys, investigations, permit applications, and other work performed by consultants shall be coordinated with THC by or through TxDOT's Environmental Affairs Division, or its successor as established by TxDOT administration, unless it and THC agree in writing to allow other appropriate organizational units of TxDOT or other entities approved by the respective agencies to coordinate the work.

§2.257. Projects Excluded from Review for Archeological Resources and Cemeteries.

(a) Routine roadway maintenance projects and projects with minor levels of ground disturbance, by their nature and definition, do not have the potential to affect historic properties, and do not require review of their potential project impacts on archeological resources or cemeteries by THC under 13 TAC Chapter 26 (relating to Practice and Procedure) or under this MOU. Such projects include vegetation control, traffic control, routine painting and striping, and other activities with less than 100 cubic yards of ground disturbance below the original grade. The following activities also do not require review of their potential impacts on archeological resources or cemeteries under 13 TAC Chapter 26 or under this MOU:

(1) installation, repair, or replacement of fencing, signage, traffic signals, railroad warning devices, safety end treatments, cameras, and intelligent highway system equipment;

(2) projects involving purchase or acquisition of land without associated ground-disturbing activities;

(3) routine structural maintenance and repair of bridges, highways, railroad crossings, picnic areas, and rest areas;

(4) in-kind repair, replacement of lighting, signals, curbs and gutters, and sidewalks;

(5) crack seal, overlay, milling, grooving, resurfacing, and restriping;

(6) replacement, upgrade, and repair of safety barriers, ditches, storm drains, and culverts;

(7) intersection improvements, including repair or replacement of overpasses, that require less than 0.5 acres of additional right of way at each intersection;

(8) placement of riprap to prevent erosion of waterway banks and bridge piers provided no ground disturbance is required;

(9) all maintenance work between a highway and an adjacent frontage road;

(10) installation of noise barriers or alterations to existing publicly owned buildings less than 50 years old, to provide for noise reduction except in potential or listed National Register districts;

(11) driveway and street connections;

(12) all work within interchanges and within medians of divided highways;

(13) all work between the flowlines of the ditches and channels and above the original line and grade;

(14) ditch and channel maintenance, provided removal of fill is above the original line and grade;

(15) repairs needed as a result of an event, natural or man-made, which causes damage to a designated state highway, resulting in an imminent threat to life or property of the traveling public or which substantially disrupts or may disrupt the orderly flow of traffic and commerce;

(16) the installation and modification of sidewalks (including the addition of American with Disabilities Act (ADA) ramps) except:

(A) sidewalk installations where the depth of impact exceeds one foot;

(B) sidewalk and ADA ramp projects within the historic districts in the following cities or towns: Goliad, Rio Grande City, Roma, San Antonio, San Elizario, and San Ygnacio; and

(C) sidewalk or ADA ramp projects within the limits of the following cities or towns: Anahuac, Nacogdoches, San Patricio, and Socorro;

(17) design changes for projects that have completed all applicable review and consultation where the new project elements comprise only one or more of the activities listed in this section; or

(18) other kinds of undertakings jointly agreed to in writing by THC and TxDOT.

(b) Projects that are exempt from project-specific review for compliance with 13 TAC Chapter 26 and review under this MOU, as specified in subsection (a) of this section, are also exempt from compliance with other THC rules regarding project-specific investigations or coordination for potential impacts to cemeteries promulgated under Health and Safety Code, §711.012(c), unless one of the following two conditions is present:

(1) pavement would be extended to within 15 feet of the boundary of a known cemetery founded earlier than 1955; or

(2) another project element would directly affect known burials.

§2.258. Procedures for Project Coordination when the Project Requires Review for Archeological Resources and Cemeteries.

(a) For projects subject to review for archeological resources and cemeteries under this MOU, TxDOT will evaluate the APE for potential project effects to archeological historic properties and to determine whether the APE contains cemeteries. TxDOT must make reasonable efforts and act in good faith when complying with this requirement.

(b) TxDOT may approve projects to proceed to construction without review by THC when TxDOT staff finds that the project will not affect archeological historic properties and the project APE will not contain cemeteries.

(c) TxDOT will submit a quarterly report of projects evaluated and approved internally to THC.

(d) TxDOT will submit projects to THC for review when TxDOT staff finds the project may affect archeological historic properties or the project APE contains cemeteries. TxDOT may, at its discretion, submit projects for THC review in cases where TxDOT staff finds that the project will not affect archeological historic properties, and the project APE does not contain cemeteries.

(e) In its request for review, TxDOT will make one or more of the following findings, determinations, and recommendations:

(1) in cases where no archeological sites or cemeteries occur or are likely to occur in some or all of the APE, TxDOT will propose a finding of no effect in those portions of the APE and recommend that the project proceed to construction in those portions;

(2) in cases where an archeological site occurs within the APE but the portion of the site within the APE does not have characteristics that qualify it as an archeological historic property or is not likely to have such characteristics, TxDOT will propose a determination that the portion of the site in the APE is not an archeological historic property, find that the project will have no effect on archeological historic properties at the site location, and recommend that the project proceed to construction at the location of the site;

(3) in cases where the portion of a site within the APE has characteristics that qualify it as an archeological historic property, TxDOT will propose a determination that an archeological historic property occurs within the APE;

(4) in cases where the APE contains an archeological historic property or cemetery, TxDOT will either propose a finding that the project will have no adverse effect on the site or propose a finding that the project will have an adverse effect on the site; or

(5) if a project will have an adverse effect on an archeological historic property or cemetery within the APE, TxDOT will also recommend to THC an appropriate means by which to resolve the potential adverse effect.

(f) The resolution of adverse effects may take one of the following forms:

(1) the avoidance of the site during construction;

(2) an alternative mitigation strategy, such as the preservation of a comparable site or the re-analysis of an existing collection;

(3) data recovery excavation or exhumation; or

(4) another form of resolution approved by THC.

(g) In cases where data recovery is the selected means for resolving adverse effects, TxDOT will coordinate with THC at several stages during the data recovery process according to the following procedures, unless TxDOT and THC agree in writing to different procedures:

(1) TxDOT will submit an initial data recovery plan as part of a permit application for data recovery to THC for review;

(2) TxDOT will submit a brief report, documenting whether the fieldwork met the terms of the initial data recovery plan and justifying any deviation, to THC for review. When appropriate, TxDOT will recommend that the project be approved to proceed to construction and destruction of any remaining portion of the site within the APE;

(3) TxDOT will submit a revised data recovery plan, based on a preliminary review of field data and recovered materials, to THC for review. When appropriate, TxDOT will recommend that the revised plan be adopted for the completion of data recovery analysis and reporting;

(4) TxDOT will submit a draft data recovery report to THC for review. When appropriate, TxDOT will recommend that the report be accepted in partial satisfaction of the terms of the permit and in satisfaction of TxDOT's obligations for resolving the adverse effects of the project on the site; or

(5) TxDOT will ensure that data recovery investigations do not begin before the State of Texas' legal right to ownership of the artifacts to be recovered has been secured.

(h) THC will respond within 20 calendar days of receipt of the TxDOT request for review. The response will include:

(1) a statement of concurrence or nonconcurrence with TxDOT's findings and recommendations;

(2) a determination of site eligibility for all evaluated sites; and

(3) any other comments relevant to the archeological resources or cemeteries which could be affected by the project.

(i) If THC does not respond within 20 calendar days, TxDOT may assume that THC concurs with TxDOT's findings, determinations, and recommendations and may proceed with the project in accordance with the procedures required in this MOU.

§2.259. Background Studies for Archeological Resources and Cemeteries.

(a) For projects subject to review for archeological resources and cemeteries under this MOU, based on the results of background research, TxDOT will identify projects or portions of projects' APEs that require archeological field investigation.

(b) Eligibility determinations that TxDOT performs under this MOU will not require field investigations if sufficient background information exists to demonstrate that the portion of the site to be affected does not have potential research value.

(c) Determinations that TxDOT makes under this MOU regarding the presence of cemeteries in project APEs may be made through the use of maps, project-area photographs, or other background research.

§2.260. Permits for Archeological Resources and Cemeteries.

(a) THC shall issue antiquities permits for reconnaissance survey, intensive survey, monitoring, eligibility testing, exhumations, and emergencies to archeological staff at TxDOT under the following terms:

(1) the archeological staff of TxDOT's Environmental Affairs Division, or its successor as established by TxDOT administration, oversees the work;

(2) the work shall be completed in accordance with the provisions of the MOU; and

(3) THC shall not require TxDOT to submit an antiquities permit application.

(b) In lieu of a permit application, TxDOT archeological staff shall notify THC in writing (by email or letter) of:

(1) the principal investigator;

(2) the investigation type and scope of work;

(3) the county in which the project will occur;

(4) the project name or identifier (site trinomial, if applicable); and

(5) the period of time for which the permit is desired.

(c) TxDOT staff may initiate work following notification of THC.

(d) THC shall issue a permit number within five business days of receiving the notification.

(e) TxDOT may revise the type of investigation based on observations made during the conduct of work as long as TxDOT provides to THC notification of the change prior to submission of the report.

(f) When conditions of natural disasters, man-made disasters, or post-review discovery necessitate immediate action, TxDOT may initiate work under an emergency permit without having first requested and received the permit number subject to the following conditions:

(1) TxDOT staff shall only conduct work under an emergency permit when archeological deposits are discovered during development or other construction projects or under conditions of natural or man-made disasters that necessitate immediate action to deal with the situation and findings;

(2) TxDOT will provide notification to THC to obtain the permit number within five working days of initiating the work; and

(3) all categories of investigations can be authorized under an emergency permit, but an emergency permit will only be issued under emergency conditions where the investigations must be initiated or performed prior to notification under subsection (b) of this section.

(g) THC shall consider the work conducted under the permit completed upon receipt of:

(1) one unbound report;

(2) two tagged pdf format reports on an archival quality CD or DVD, one containing all maps and locational information and one with maps and locational information redacted;

(3) a shape file of the project area subject to investigation; and

(4) a completed abstract form.

(h) The number of defaulted permits accrued by particular TxDOT staff while working for TxDOT shall not affect the issuance of additional permits to other TxDOT staff by THC for TxDOT projects.

(i) The inspection of a project APE or proposed APE for purposes of evaluating the kind of archeological investigation that may be required (scoping) shall not constitute an activity that requires a permit

from THC when that activity does not result in a report to be coordinated under the terms of the MOU.

(j) All types of archeological investigations conducted by TxDOT but not covered by this section shall require submission of an antiquities permit application and adhere to the terms of the permit and 13 TAC Chapter 26 (relating to Practice and Procedure).

§2.261. Surveys for Archeological Resources and Cemeteries.

(a) Surveys may be limited to an evaluation of existing impacts or stratigraphic integrity when these activities are sufficient to determine that any sites present are unlikely to be eligible.

(b) Eligibility determinations that TxDOT performs under this MOU do not require subsurface investigation if it can be demonstrated that the portion of the site to be affected is not likely to have sufficient integrity to be eligible.

(c) For portions of the APE where deposits may retain sufficient integrity for sites to be eligible, TxDOT survey methods will conform with THC's Archeological Survey Standards or with other appropriate methods, except as provided in paragraphs (1) and (2) of this subsection:

(1) TxDOT reserves the right to depart from published survey standards in cases where it deems appropriate; and

(2) THC reserves the right to review non-standard procedures for their adequacy.

(d) Survey methods will be considered adequate for the identification of burials and cemetery boundaries when the portions of the APE within 25 feet of a known cemetery have been investigated and the survey included scraping to a depth adequate to determine whether grave shafts or burials occur in the APE.

(e) A survey to identify burials does not comprise an activity with the potential to cause an adverse effect to a historic property.

§2.262. Archeological Eligibility Testing Phase.

(a) The following methods will be employed for test excavations:

(1) mechanical trenches will be excavated and profiles documented in order to characterize the area's potential for archeological deposits with sufficient integrity to be eligible to occur at the site;

(2) the extent of the site within the APE will be sampled through some combination of shovel-testing, column sampling, augering, surface collection, and geophysical prospection in order to characterize the distribution of archeological materials across the site;

(3) additional units will be excavated and screened to evaluate site areas that appear to have the best potential for yielding important data with good integrity, based on the results of previous work; and

(4) the materials analyzed will comprise those materials most likely to contribute important information about prehistory or history.

(b) TxDOT reserves the right to depart from these methods in cases where it deems appropriate and shall justify deviations in the report.

(c) Data from test excavation projects shall be made available to qualified researchers.

§2.263. Archeological Excavation and Data Recovery.

(a) When appropriate and established in the final research design approved by THC, TxDOT will develop public educational outreach projects for significant data recovery investigations.

(b) Data from data recovery projects shall be made available to qualified researchers.

§2.264. Exhumation.

(a) Exhumation is a form of investigation to resolve the adverse effects of a project on a cemetery.

(b) Exhumation efforts may be staged as a separate phase of work from burial identification. Following procedures set forth in Health and Safety Code, Chapter 711, exhumation may begin once any required notifications of next of kin or other procedures required by Health and Safety Code, Chapter 711 have been conducted.

(c) The following tasks represent a sufficient, reasonable, and good faith effort to identify remains and any next of kin associated with burials in unknown or abandoned cemeteries:

(1) making inquiries through the local County Historical Commission;

(2) posting notices with local news outlets; and

(3) posting notices with local churches.

(d) An exhumation project is itself not a type of investigation that requires an outreach effort or curation of materials at a state-certified facility.

§2.265. Archeological Sites found after Award of Contract.

(a) When previously unknown archeological remains are encountered after award of a construction contract, TxDOT will immediately suspend construction or any other activities that would affect the site.

(b) TxDOT will inform THC of the discovery of previously unknown archeological remains and invite THC to accompany TxDOT staff (or consultants) to the location within ten business days of the discovery.

(c) TxDOT, in consultation with THC, will evaluate the need, if any, for further investigations.

(d) If TxDOT determines that the discovery is an unrecorded archeological site, then TxDOT or its consultants shall complete an electronic TexSite archeological site survey form.

(e) If TxDOT determines that the site does not warrant further investigations because it is not a historic property, construction will resume. TxDOT will document its findings.

(f) If TxDOT determines that the site warrants further investigation because the site may be a historic property, TxDOT will take one of the following three actions, as appropriate:

(1) a permit amendment will be sent to THC for the additional work, if an existing permit for the project is still open;

(2) a notification for a new permit will be sent to THC; or

(3) TxDOT will perform necessary investigations under an emergency permit.

(g) Upon completion of the investigation in accordance with any applicable permit terms, construction may proceed as planned.

§2.266. Standard Treatments for Particular Resource Types.

(a) Isolated wells or cisterns unassociated with other remains will be treated as follows:

(1) isolated wells or cisterns that post-date 1900 A.D. do not warrant notification of THC or additional investigation. Removal or sealing of these features does not constitute an adverse effect; and

(2) isolated wells or cisterns that pre-date 1900 A.D. require documentation of their location, construction, and condition. Upon completion of the documentation, these features may be backfilled and capped. These activities do not constitute an adverse effect.

(b) Burnt rock midden features that have not been obviously destroyed by modern disturbances will be treated as follows:

(1) the feature will be trenched to expose a cross-section;

(2) the exposed profiles will be documented, focusing on the identification of any internal structure;

(3) column samples will be taken from the exposed profile in order to collect samples for flotation and dating from each deposit recognized in the profile;

(4) deviations from this standard approach may be undertaken if TxDOT coordinates an alternate approach with THC; and

(5) any additional work on the feature will be determined in consultation between TxDOT and THC, based on the results of the trenching.

§2.267. Artifact Recovery and Curation.

(a) Artifact recovery.

(1) Artifacts or analysis samples (such as soil samples) that are recovered from survey, testing, or data recovery investigations by TxDOT or their contracted agents that address the research questions must be cleaned, labeled, and processed in preparation for long-term curation unless the artifacts or samples are approved by THC for discard under 13 TAC Chapters 26 and 29 (relating to Practice and Procedure; and Management and Care of Artifacts and Collections, respectively).

(2) To ensure proper care and curation, recovery methods must conform to the applicable requirements of 13 TAC Chapters 26 and 29.

(b) Artifact curation.

(1) TxDOT or its permitted contractor may temporarily house artifacts and samples during laboratory analysis and research, but upon completion of the analysis, artifacts and accompanying documentation must be transferred to a permanent curatorial facility in accordance with the terms of the antiquities permit.

(2) Artifacts and samples will be placed at an appropriate artifact curatorial repository which fulfills the applicable requirements of 13 TAC Chapter 29 as approved by THC. When appropriate, TxDOT will consult with THC to identify for disposal collections or portions of collections that do not have identifiable value for future research or public interpretation. Final approval regarding the disposition of collections will be made by THC.

(3) TxDOT is responsible for the curatorial preparation of all artifacts to be submitted for curation so that they are acceptable to the receiving curatorial repository and fulfill the applicable requirements of 13 TAC Chapters 26 and 29, as approved by THC.

§2.268. Documentation for Archeological Resources and Cemeteries.

(a) Projects subject to review for archeological resources and cemeteries under this MOU will be documented by TxDOT in the manner described in this section. Documentation for each such project will include, at a minimum:

(1) a description of the project, defining the APE or the investigated portion of the APE in three dimensions;

(2) a project location map, plotting the project location on 7.5' Series USGS quadrangle maps;

(3) information regarding the setting that is relevant for the assessment of the integrity of any archeological sites within the APE;

(4) information on previously recorded archeological sites in the project location;

(5) description and justification of the level of effort undertaken for the investigation; and

(6) results and recommendations.

(b) All TxDOT survey and testing reports will also include:

(1) description and justification of field methods, including the sampling strategy;

(2) description and quantification of any archeological materials identified;

(3) accurate plotting of any sites found on 7.5' Series USGS quadrangle maps;

(4) submission of electronic TexSite archeological site survey forms to the Texas Archeological Research Laboratory; and

(5) recommendations regarding whether any site merits further investigation.

§2.269. Quarterly Reports for Archeological Resources and Cemeteries.

Quarterly reports will be submitted by TxDOT to THC within 60 business days after the end of the calendar quarter, listing all projects for which TxDOT has documented that no historic properties or cemeteries are present in the project's area of potential effect, and those projects that will have no adverse effects on archeological historic properties or cemeteries.

§2.270. Projects Excluded from Review for Non-Archeological Historic Properties.

(a) For the purposes of this section, the term historic properties will refer only to non-archeological historic properties.

(b) Based on previous coordination outcomes, TxDOT and THC agree that the following types of routine roadway projects pose limited potential to affect historic properties:

(1) maintenance, repair, installation, or replacement, of transportation-related features, including fencing, signage, traffic signals, railroad warning devices, safety end treatments, cameras and intelligent highway system equipment, bridges, railroad crossings, picnic areas, rest areas, roadside parks, lighting, curbs and gutters, safety barriers, ditches, storm drains, culverts, overpasses, channels, rip rap, and noise barriers;

(2) maintenance, repair, or replacement of roadway surfacing, including crack seal, overlay, milling, grooving, resurfacing, and restriping;

(3) maintenance, repair, reconfiguration, or correction of roadway geometrics, including intersection improvements and driveway and street connections;

(4) maintenance, repair, installation or modification of pedestrian and cycling-related features, including American with Disabilities Act ramps, trails, sidewalks, and bicycle and pedestrian lanes;

(5) maintenance, repair, relocation, addition, or minor widening of roadway, highway, or freeway features, including turn

bays, center turn lanes, shoulders, U-turn bays, right turn lanes, travel lanes, interchanges, medians, and ramps;

(6) maintenance, repair, replacement, or relocation of features at crossings of irrigation canals, including bridges, new vehicle crossings, bank reshaping, pipeline and standpipe components, canal conversion to below-grade siphons, and utilities;

(7) repairs needed as a result of an event, natural or man-made, which causes damage to a designated state highway, resulting in an imminent threat to life or property of the traveling public, or which substantially disrupts or may disrupt the orderly flow of traffic and commerce;

(8) design changes for projects that have completed all applicable review and consultation where the new project elements comprise only one or more of the activities listed in this subsection; and

(9) other kinds of undertakings jointly agreed to in writing by THC and TxDOT as not requiring review.

(c) For projects described by subsection (b) of this section, TxDOT qualified professional staff shall determine whether additional evaluation is required due to direct effects to historic properties. If no such evaluation is deemed necessary, such projects are determined to pose no effect on historic properties and do not require review by THC under 13 TAC Chapter 26 (relating to Practice and Procedure) or under this MOU.

(d) For review-exempt projects, documentation shall be limited to that maintained in TxDOT's official project files. THC may audit TxDOT files for specific projects upon request.

§2.271. Procedures for Project Coordination when the Project Requires Review for Non-Archeological Historic Properties.

(a) Historic properties. For the purposes of this section, the term historic properties will refer only to non-archeological historic properties.

(b) Internal review projects. For projects subject to review for historic properties under this MOU, TxDOT qualified professional staff shall determine the presence or absence of historic properties in the area of potential effects. Such efforts should focus on the types of historic properties within public rights-of-way and other sensitive areas, including but not limited to historic bridges, historic road corridors, historic roadside parks and rest areas, historic Depression Era masonry culverts, historic districts, historic courthouse squares and other historic commercial zones. Project activities that TxDOT determines will have no effect or no adverse effect on historic properties may be internally reviewed by TxDOT and are approved for construction. Documentation for such projects will be maintained in official TxDOT project files and regularly reported to THC in accordance with subsection (d)(1) of this section.

(c) Coordinated projects. Projects subject to review for historic properties under this MOU that are determined by TXDOT qualified professional staff to pose an adverse effect on historic properties shall require individual THC review according to the following procedures:

(1) THC will respond within 20 calendar days of receipt of TxDOT's request for review by indicating whether an affected historic property will require a historic structures permit for an SAL, or whether THC intends to initiate an SAL nomination for the affected property. If THC does not respond within 20 calendar days, TxDOT may assume THC's concurrence with its determinations, and TXDOT may proceed with the project to construction;

(2) in accordance with Government Code, §442.008 and 13 TAC §17.2 (relating to Review of Work on County Courthouses), TxDOT will notify THC of any work affecting a county courthouse or its surrounding site, up to and including the curb. THC will respond within 20 calendar days of receipt of TxDOT's notification by indicating whether a historic structures permit for an SAL or additional consultation pursuant to a preservation covenant or easement will be required; and

(3) state-funded projects coordinated under this MOU that may subsequently require a federal permit or change to federal funding, and that involve a direct taking of a historic property, must be individually coordinated with THC in order to satisfy federal regulations under 23 C.F.R. Part 774 and 36 C.F.R. Part 800. Procedures outlined in the 2005 PA-TU or subsequent agreements will govern such coordination.

(d) Documentation. For projects that are internally reviewed or individually coordinated under subsections (b) and (c) of this section, TxDOT will comply with the following project documentation requirements:

(1) for projects that are internally reviewed under subsection (b) of this section, TxDOT will submit to THC a quarterly report of internally approved projects within 60 business days after the end of the calendar quarter. THC may audit TxDOT files for specific projects submitted in the quarterly report. Quarterly report documentation will include:

(A) project description and scope;

(B) project location map with delineation of the APE and location of historic properties;

(C) methodology used to identify historic properties;

(D) photographic and descriptive information for each identified property;

(E) description of public involvement activities;

(F) justification for findings of historic properties, including setting, integrity, and contextual information; and

(G) justification of effects on historic properties, including evaluations, reports, and other information relevant to the findings by TxDOT; and

(2) for projects that are individually coordinated under subsection (c) of this section, documentation submitted to THC will include the items listed in paragraph (1)(A) - (G) of this subsection, and a description of efforts to avoid or minimize harm, mitigation, and commitments.

§2.272. Denial of Access.

In cases where access to private land for conducting investigations is denied prior to the approval of the environmental review document, TxDOT will make a commitment to complete appropriate investigations once access is obtained, but prior to any construction related impacts.

§2.273. MOU to Govern TxDOT Procedures.

TxDOT satisfies applicable THC requirements if it utilizes the procedures of this MOU in lieu of other THC procedures. In cases where TxDOT is utilizing this MOU in lieu of other THC procedures, TxDOT must follow the requirements of this MOU.

§2.274. Project-Specific Agreements.

Any project-specific agreement reached between TxDOT and THC regarding the evaluation or treatment of project effects shall be honored by both parties and shall supersede the requirements of this MOU. TxDOT and THC may deviate from the terms of the agreement only when both parties concur that the agreement requires revision.

§2.275. Continuous Improvement Agreement.

TxDOT and THC agree to collaborate on improvements to their programs and development of innovative solutions for expedited review procedures. Such mechanisms may include using project outcomes to refine approaches to resource identification, evaluation, treatment methods, programmatic mitigation measures and interagency agreements that facilitate early coordination, and streamlining and expedited review of TxDOT's transportation projects.

§2.276. THC Review of TxDOT Project Files.

THC may review TxDOT project files for specific undertakings carried out under this MOU. THC may recommend process improvements based on issues identified during the review.

§2.277. Dispute Resolution.

THC and TxDOT staff will be responsible for attempting to resolve any conflict between THC and TxDOT that results from the implementation of this subchapter before elevating to agency management.

§2.278. Review of MOU.

This memorandum of understanding shall be reviewed and updated as provided by law or by agreement between the parties. THC and TxDOT agree to convene every four years to review, update, or extend this agreement.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300410
Jeff Graham
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 463-8683

♦ ♦ ♦

CHAPTER 7. RAIL FACILITIES
SUBCHAPTER D. RAIL SAFETY

43 TAC §7.31

The Texas Department of Transportation (department) proposes amendments to §7.31, concerning safety requirements.

EXPLANATION OF PROPOSED AMENDMENTS

During the department's rule review process, the Rail Division identified several changes that are necessary to update §7.31, Safety Requirements.

Amendments to §7.31 combine the laws listed in existing subsections (b) and (c), that provide safety requirements applicable to railroads operating in Texas, into a single list and revise references to certain laws. Texas Civil Statutes, Article 6492a has been revised as Transportation Code, Chapter 193 and the amendments to §7.31(b)(4) reflect that change. The references to 49 C.F.R. Part 40 and 49 C.F.R. Parts 107 and 171-180 are moved from existing subsection (c)(1) and (2) to new subsection (b)(5) and (6), respectively. The references to the specific provisions of the Code of Federal Regulations contained in existing subsection (c)(3) - (24) are changed to a more general reference and transferred to subsection (b)(7). Existing subsection (c) is deleted as a result of the combination of the two subsections.

FISCAL NOTE

James Bass, Chief Financial Officer, has determined that for each year of the first five years in which the proposed amendments are in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the amendments.

Jeff Graham, General Counsel, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the amendments.

PUBLIC BENEFIT AND COST

Mr. Graham has also determined that for each year of the first five years in which the amendments are in effect, the public benefit anticipated as a result of enforcing or administering the amendments will be clarity in the department's rules. There are no anticipated economic costs for persons required to comply with the section as proposed. There will be no adverse economic effect on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the proposed amendments to §7.31 may be submitted to Robin Carter, Office of General Counsel, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78701-2483 or to RuleComments@txdot.gov with the subject line "7.31." The deadline for receipt of comments is 5:00 p.m. on March 18, 2013. In accordance with Transportation Code, §201.811(a)(5), a person who submits comments must disclose, in writing with the comments, whether the person does business with the department, may benefit monetarily from the proposed amendments, or is an employee of the department.

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE

Transportation Code, Chapters 111 and 193.

§7.31. Safety Requirements.

(a) Applicability. A person, association, private corporation, public corporation, or any other entity that owns or operates a railroad shall comply with the requirements of this subchapter.

(b) Governing statutes. Railroads operating within the state of Texas shall comply with the safety requirements contained in or adopted under [~~the following statutes~~]:

(1) 49 United States Code, Subtitle III, Chapter 51;

(2) 49 United States Code, Subtitle V, Part A;

(3) Transportation Code, Chapter 111; [~~and~~]

(4) Transportation Code, Chapter 193; [~~Texas Civil Statutes, Article 6492a.~~]

(5) 49 C.F.R. Part 40;

(6) 49 C.F.R. Parts 107 and 171 - 180; and

(7) 49 C.F.R. Subtitle B, Chapter II, Federal Railroad Administration, Department of Transportation, Parts 200 - 299.

[~~(c) Federal regulations adopted by reference. The following federal railroad safety requirements, as they exist on the effective date of this rule, are adopted by the department as the minimum railroad safety requirements, and all railroads operating within the state of Texas shall comply with them:~~]

[(1) transportation workplace drug testing programs, codified at 49 C.F.R. Part 40;]

[(2) hazardous materials regulations, codified at 49 C.F.R. Parts 107 and 171-180;]

[(3) track safety standards, codified at 49 C.F.R. Part 213;]

[(4) railroad workplace safety standards, codified at 49 C.F.R. Part 214;]

[(5) freight car safety standards, codified at 49 C.F.R. Part 215;]

[(6) special notice and emergency order procedures, codified at 49 C.F.R. Part 216;]

[(7) federal operating practice regulations, codified at 49 C.F.R. Parts 217, 218, 220, 221, 225, and 228;]

[(8) control of alcohol and drug use, codified at 49 C.F.R. Part 219;]

[(9) locomotive horns at public highway-rail crossings regulations, codified at 49 C.F.R. Part 222;]

[(10) safety glazing standards, codified at 49 C.F.R. Part 223;]

[(11) reflectorization of rail freight rolling stock regulations, codified at 49 C.F.R. Part 224;]

[(12) occupational noise exposure, codified at 49 C.F.R. Part 227;]

[(13) locomotive safety standards, codified at 49 C.F.R. Part 229;]

[(14) steam locomotive inspection and maintenance standards regulations, codified at 49 C.F.R. Part 230;]

[(15) safety appliance standards, codified at 49 C.F.R. Part 231;]

[(16) power brake standards, codified at 49 C.F.R. Part 232;]

[(17) signal system reporting requirements, codified at 49 C.F.R. Part 233;]

[(18) grade crossing signal system safety, codified at 49 C.F.R. Part 234;]

[(19) instructions governing applications for approval of a discontinuance or material modification of a signal system or relief from the requirements of 49 C.F.R. Part 236, codified at 49 C.F.R. Part 235;]

[(20) rules, standards, and instructions for railroad signal systems, codified at 49 C.F.R. Part 236;]

[(21) bridge safety standards, codified at 49 C.F.R. Part 237;]

[(22) passenger equipment safety standards regulations, codified at 49 C.F.R. Part 238;]

[(23) passenger train emergency preparedness regulations, codified at 49 C.F.R. Part 239; and]

[(24) qualifications and certification of locomotive engineers, codified at 49 C.F.R. Part 240.]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300417
Jeff Graham
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: March 17, 2013
For further information, please call: (512) 463-8683

♦ ♦ ♦

WITHDRAWN RULES

Withdrawn Rules include proposed rules and emergency rules. A state agency may specify that a rule is withdrawn immediately or on a later date after filing the notice with the Texas Register. A proposed rule is withdrawn six months after the date of publication of the proposed rule in the Texas Register if a state agency has failed by that time to adopt, adopt as amended, or withdraw the proposed rule. Adopted rules may not be withdrawn. (Government Code, §2001.027)

TITLE 1. ADMINISTRATION

PART 3. OFFICE OF THE ATTORNEY GENERAL

CHAPTER 55. CHILD SUPPORT ENFORCEMENT

SUBCHAPTER M. INTERCEPT OF INSURANCE CLAIMS

1 TAC §§55.601 - 55.605

The Office of the Attorney General withdraws the proposed amendments to §§55.601 - 55.605 which appeared in the August 31, 2012, issue of the *Texas Register* (37 TexReg 6833).

Filed with the Office of the Secretary of State on February 4, 2013.

TRD-201300439
Katherine Cary
General Counsel
Office of the Attorney General
Effective date: February 4, 2013
For further information regarding this publication, please contact Diane Morris, Agency Liaison, at (512) 936-1180.

♦ ♦ ♦

CHAPTER 66. FAMILY TRUST FUND DISBURSEMENT PROCEDURES

SUBCHAPTER A. GENERAL PROVISIONS AND ELIGIBILITY

1 TAC §§66.1 - 66.3, 66.5, 66.7, 66.9

The Office of the Attorney General withdraws the proposed repeal of §§66.1 - 66.3, 66.5, 66.7, and 66.9 which appeared in the September 7, 2012, issue of the *Texas Register* (37 TexReg 7019).

Filed with the Office of the Secretary of State on February 4, 2013.

TRD-201300440
Katherine Cary
General Counsel
Office of the Attorney General
Effective date: February 4, 2013
For further information regarding this publication, please contact Diane Morris, Agency Liaison, at (512) 936-1180.

♦ ♦ ♦

SUBCHAPTER B. GRANT APPLICATION, SCOPE OF GRANT, APPROVAL AND FUNDING

1 TAC §§66.15, 66.17, 66.19, 66.21, 66.23

The Office of the Attorney General withdraws the proposed repeal of §§66.15, 66.17, 66.19, 66.21, and 66.23 which appeared in the September 7, 2012, issue of the *Texas Register* (37 TexReg 7019).

Filed with the Office of the Secretary of State on February 4, 2013.

TRD-201300441
Katherine Cary
General Counsel
Office of the Attorney General
Effective date: February 4, 2013
For further information regarding this publication, please contact Diane Morris, Agency Liaison, at (512) 936-1180.

♦ ♦ ♦

SUBCHAPTER C. SPECIAL CONDITIONS AND REQUIRED DOCUMENTS

1 TAC §§66.33, 66.35, 66.37, 66.41, 66.47

The Office of the Attorney General withdraws the proposed repeal of §§66.33, 66.35, 66.37, 66.41, and 66.47 which appeared in the September 7, 2012, issue of the *Texas Register* (37 TexReg 7020).

Filed with the Office of the Secretary of State on February 4, 2013.

TRD-201300443
Katherine Cary
General Counsel
Office of the Attorney General
Effective date: February 4, 2013
For further information regarding this publication, please contact Diane Morris, Agency Liaison, at (512) 936-1180.

♦ ♦ ♦

SUBCHAPTER D. AWARD AND GRANT ACCEPTANCE

1 TAC §§66.55, 66.57, 66.59

The Office of the Attorney General withdraws the proposed repeal of §§66.55, 66.57, and 66.59 which appeared in the

September 7, 2012, issue of the *Texas Register* (37 TexReg 7020).

Filed with the Office of the Secretary of State on February 4, 2013.

TRD-201300444
Katherine Cary
General Counsel
Office of the Attorney General
Effective date: February 4, 2013
For further information regarding this publication, please contact Diane Morris, Agency Liaison, at (512) 936-1180.

♦ ♦ ♦

SUBCHAPTER E. ADMINISTERING GRANTS

1 TAC §§66.67, 66.69, 66.75, 66.77, 66.79, 66.93, 66.95, 66.99, 66.101, 66.103, 66.105, 66.107, 66.109, 66.111

The Office of the Attorney General withdraws the proposed repeal of §§66.67, 66.69, 66.75, 66.77, 66.79, 66.93, 66.95, 66.99, 66.101, 66.103, 66.105, 66.107, 66.109, and 66.111 which appeared in the September 7, 2012, issue of the *Texas Register* (37 TexReg 7020).

Filed with the Office of the Secretary of State on February 4, 2013.

TRD-201300445
Katherine Cary
General Counsel
Office of the Attorney General
Effective date: February 4, 2013
For further information regarding this publication, please contact Diane Morris, Agency Liaison, at (512) 936-1180.

♦ ♦ ♦

SUBCHAPTER F. PROGRAM MONITORING AND AUDITS

1 TAC §66.119, §66.123

The Office of the Attorney General withdraws the proposed repeal of §66.119 and §66.123 which appeared in the September 7, 2012, issue of the *Texas Register* (37 TexReg 7021).

Filed with the Office of the Secretary of State on February 4, 2013.

TRD-201300446
Katherine Cary
General Counsel
Office of the Attorney General
Effective date: February 4, 2013
For further information regarding this publication, please contact Diane Morris, Agency Liaison, at (512) 936-1180.

♦ ♦ ♦

TITLE 16. ECONOMIC REGULATION

PART 1. RAILROAD COMMISSION OF TEXAS

CHAPTER 3. OIL AND GAS DIVISION

16 TAC §§3.13, 3.99, 3.100

The Railroad Commission of Texas withdraws the proposed amendments to §§3.13, 3.99 and 3.100, which appeared in the September 7, 2012, issue of the *Texas Register* (37 TexReg 7021).

Filed with the Office of the Secretary of State on January 30, 2013.

TRD-201300354
Cristina Martinez Self
Rules Attorney, Office of General Counsel
Railroad Commission of Texas
Effective date: January 30, 2013
For further information, please call: (512) 476-1295

♦ ♦ ♦

TITLE 19. EDUCATION

PART 1. TEXAS HIGHER EDUCATION COORDINATING BOARD

CHAPTER 4. RULES APPLYING TO ALL PUBLIC INSTITUTIONS OF HIGHER EDUCATION IN TEXAS

SUBCHAPTER R. REVIEW OF LOW-PRODUCING DEGREE PROGRAMS

19 TAC §4.287, §4.291

The Texas Higher Education Coordinating Board withdraws the proposed amendments to §4.287 and §4.291 which appeared in the August 10, 2012, issue of the *Texas Register* (37 TexReg 5958).

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300381
Bill Franz
General Counsel
Texas Higher Education Coordinating Board
Effective date: February 1, 2013
For further information, please call: (512) 427-6114

♦ ♦ ♦

CHAPTER 17. RESOURCE PLANNING

SUBCHAPTER B. BOARD APPROVAL

19 TAC §17.13

The Texas Higher Education Coordinating Board withdraws the proposed amendment to §17.13 which appeared in the November 30, 2012, issue of the *Texas Register* (37 TexReg 9426).

Filed with the Office of the Secretary of State on January 30, 2013.

TRD-201300351

Bill Franz
General Counsel
Texas Higher Education Coordinating Board
Effective date: January 30, 2013
For further information, please call: (512) 427-6114

♦ ♦ ♦

SUBCHAPTER C. RULES APPLYING TO ALL PROJECTS

19 TAC §17.20

The Texas Higher Education Coordinating Board withdraws the proposed amendment to §17.20 which appeared in the November 30, 2012, issue of the *Texas Register* (37 TexReg 9426).

Filed with the Office of the Secretary of State on January 30, 2013.

TRD-201300352
Bill Franz
General Counsel
Texas Higher Education Coordinating Board
Effective date: January 30, 2013
For further information, please call: (512) 427-6114

♦ ♦ ♦

ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 13. CULTURAL RESOURCES

PART 2. TEXAS HISTORICAL COMMISSION

CHAPTER 28. HISTORIC SHIPWRECKS

13 TAC §28.6, §28.9

The Texas Historical Commission (Commission) adopts amendments to §28.6 and §28.9, concerning Historic Shipwrecks, without changes to the proposed text as published in the November 23, 2012, issue of the *Texas Register* (37 TexReg 9213).

The adoption of these amendments is needed in an effort to update and modify the rules associated with historically significant shipwrecks that are either submerged under the waterways or contained on, in, or under the public lands of the State of Texas. These amendments should improve the quality of underwater archeological investigations by streamlining and clarifying the responsibilities of principal investigators.

No comments were received on the proposed amendments.

The amendments are adopted under Title 4, Chapter 442, §442.005(q) of the Texas Government Code, and Title 9, Chapter 191, §191.052 of the Texas Natural Resources Code, which provide the Commission with the authority to promulgate rules and conditions to reasonably effect the purposes of these chapters.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300379
Mark Wolfe
Executive Director
Texas Historical Commission
Effective date: February 21, 2013
Proposal publication date: November 23, 2012
For further information, please call: (512) 463-1858

♦ ♦ ♦

CHAPTER 29. MANAGEMENT AND CARE OF ARTIFACTS AND COLLECTIONS

13 TAC §§29.5, 29.7, 29.9

The Texas Historical Commission (Commission) adopts amendments to §§29.5, 29.7, and 29.9, concerning Management and Care of Artifacts and Collections, without changes to the proposed text as published in the November 23, 2012, issue of the *Texas Register* (37 TexReg 9215).

The adoption of these amendments is needed to provide clarifications of the procedures curatorial facilities must follow to obtain or maintain certified status.

No comments were received on the proposed amendments.

The amendments are adopted under Title 4, Chapter 442, §442.005(q) of the Texas Government Code, and Title 9, Chapter 191, §191.052 of the Texas Natural Resources Code, which provide the Commission with the authority to promulgate rules and conditions to reasonably effect the purposes of these chapters.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300380
Mark Wolfe
Executive Director
Texas Historical Commission
Effective date: February 21, 2013
Proposal publication date: November 23, 2012
For further information, please call: (512) 463-1858

♦ ♦ ♦

TITLE 16. ECONOMIC REGULATION

PART 3. TEXAS ALCOHOLIC BEVERAGE COMMISSION

CHAPTER 31. ADMINISTRATION

16 TAC §31.12

The Texas Alcoholic Beverage Commission (commission) adopts new §31.12, concerning Training and Education of Commission Employees, without changes to the proposed text as published in the December 21, 2012, issue of the *Texas Register* (37 TexReg 9845). The rule will not be republished.

The new section provides that state funds may be used by the commission for the education and training of its employees in accordance with Government Code §§656.041 - 656.104. It establishes certain restrictions on training and education that may be funded by the commission, addresses supervisory approval to receive the education and training, and clarifies that such ed-

ucation and training does not affect the at-will status of the employee.

No comments were received.

The new section is adopted pursuant to Government Code §656.048, which requires state agencies to adopt rules relating to the eligibility of the agency's employees for training and education supported by the agency and the obligations assumed by those employees receiving the training and education. The section is also authorized by Alcoholic Beverage Code §5.31, which grants the commission the authority to prescribe and publish rules necessary to carry out the provisions of the Code.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 29, 2013.

TRD-201300329
Martin Wilson
Assistant General Counsel
Texas Alcoholic Beverage Commission
Effective date: February 18, 2013
Proposal publication date: December 21, 2012
For further information, please call: (512) 206-3443

♦ ♦ ♦

CHAPTER 45. MARKETING PRACTICES
SUBCHAPTER E. REGULATION OF CREDIT TRANSACTIONS
DIVISION 1. DELINQUENT LIST

16 TAC §45.121

The Texas Alcoholic Beverage Commission (commission) adopts an amendment to §45.121, concerning Credit Restrictions and Delinquent List for Liquor with changes to the proposed text as published in the November 9, 2012, issue of the *Texas Register* (37 TexReg 8906).

When this section was originally adopted in 2009, the commission indicated that it would periodically review it and shorten the time allowed from the end of the reporting period to the date of publication of the Delinquent List. The amendment as proposed would have given retailers two fewer days to pay a delinquent bill before their names appear on the Delinquent List. When a retailer's name appears on the Delinquent List, all wholesalers are on notice that they may not sell any liquor to that retailer until that delinquent account is paid in full, pursuant to Code (Code) §102.32(d).

No written comments on the proposed rule were submitted, but oral comments were made by Lance Lively (on behalf of the Texas Package Store Association), Alan Gray (on behalf of Licensed Beverage Distributors) and ML Calcote (on behalf of Republic National Distributing Co.) at a public hearing held by the staff of the commission on December 13, 2012. All three commenters indicated that the parties were working on a long-term solution to the issues addressed in this rulemaking proceeding.

Mr. Lively noted that every time the period is shortened the Delinquent List has the potential to grow. He also suggested that quite a few more single and double package store owners appeared on the list since the last rule change.

Mr. Gray noted that there is no statutory authority for any extension of time for payment beyond that which is already built into the Code. Extra days were apparently originally allowed as a nod to the use of 1930's-era technology. He indicated that approximately one million dollars of the delinquencies were attributable to mixed beverage establishments, while about $49.5 million were attributable to package stores. A large part of the package store number is attributable to two big stores. He suggested that if the top offenders were removed from the calculation, the figures might show that there was no problem caused by the elimination of two days in last year's rulemaking.

Mr. Gray stated that the original agreement was to reduce the time period by two days every year. However, he indicated that going from calendar days to business days would be acceptable. Thus, in this rulemaking the period would go from six calendar days to four business days (as opposed to the four calendar days in the proposal). Consistent with the original agreement, next year the period would go from four business days to two business days, and the following year the extra period would be eliminated entirely. In moving from calendar days to business days, however, Mr. Gray recognized that there could be an issue defining a business day. He acknowledged that federal holidays should not be included but suggested that state skeleton crew holidays should be counted as business days.

The commission believes that reducing the time period from six calendar days to four business days is appropriate and the text of the rule is modified accordingly.

§45.121. Credit Restrictions and Delinquent List for Liquor.

(a) Purpose. This section implements §§102.32, 11.61(b)(2), and 11.66 of the Texas Alcoholic Beverage Code (Code).

(b) Definitions.

(1) Alcoholic beverage--As used in this section includes only liquor, as that term is defined in §1.04 of the Code.

(2) Cash equivalent--A financial transaction or instrument that is not conditioned on the availability of funds upon presentment, including, money order, cashier's check, certified check or completed electronic funds transfer.

(3) Delinquent payment--A financial transaction or instrument that fails to provide payment in full or is returned to the Seller as unpaid for any reason, on or before the day it is required to be paid by §102.32(c) of the Code.

(4) Event--A financial transaction or instrument that fails to provide payment to a Retailer and results in a Retailer making one or more delinquent payments to one or more Sellers.

(5) Incident--A single delinquent payment.

(6) Retailer--A package store permittee, wine only package store permittee, private club permittee, private club exemption certificate permittee, mixed beverage permittee, or other retailer, and their agents, servants and employees. For purposes of this section, the holder of a winery permit issued under Chapter 16 of the Code is a retailer when the winery permit holder purchases wine from the holder of a wholesaler's permit issued under Chapter 19 of the Code for resale to ultimate consumers in unbroken packages.

(7) Seller--A wholesaler, class B wholesaler, winery, wine bottler, or local distributor and their agents, servants and employees.

(c) Invoices. A delivery of alcoholic beverages by a Seller, to a Retailer, must be accompanied by an invoice of sale showing the name and permit number of the Seller and the Retailer, a full description of the alcoholic beverages, the price and terms of sale, and the place and date of delivery.

(1) The Seller's copy of the invoice must be signed by the Retailer to verify receipt of alcoholic beverages and accuracy of invoice.

(2) The Seller and Retailer must retain invoices in compliance with the requirements of §206.01 of the Code.

(3) Invoices may be created, signed and retained in an electronic or internet based inventory system, and may be retained on or off the licensed premise.

(d) Delinquent Payment Violation. A Retailer who makes a delinquent payment to a Seller for the delivery of alcoholic beverages violates this section unless an exception applies.

(1) A Retailer who violates this section must pay a delinquent amount, and a Seller may accept payment, only in cash or cash equivalent financial transaction or instrument.

(2) A Retailer whose permit or license expires or is cancelled for cause, voluntarily cancelled, suspended or placed in suspension while on the delinquent list will be disqualified from applying for or being issued an original or renewal permit or license until all delinquent payments are satisfied. For purposes of this section, the Retailer includes all persons who were owners, officers, directors and shareholders of the Retailer at the time the delinquency occurred.

(e) Reporting Violation and Payment; Failure to Report.

(1) A report of a violation or payment must be submitted electronically to the commission on the commission's web based reporting system at www.tabc.state.tx.us.

(2) A Seller who cannot access the commission's web based reporting system must either:

(A) submit a request for exception to submit reports by paper; or

(B) contract with another seller or service provider to make electronic reports on behalf of the Seller.

(3) All reports of violations or payment under this subsection must be made to the commission on or before the date the delinquent list is published.

(4) A Seller who fails to report a violation or a payment as required by this subsection is in violation of this section.

(f) Prohibited Sales and Delivery.

(1) Sellers are prohibited from selling or delivering alcoholic beverages to any licensed location of a Retailer who appears on the commission's Delinquent List from the date the violation appears on the Delinquent List until the Release Date on the Delinquent List, or until the Retailer no longer appears on the Delinquent List.

(2) A sale or delivery of alcoholic beverages prohibited by this section is a violation of this section.

(g) Prohibited Purchase or Acceptance.

(1) A Retailer who violates subsection (d) of this section is prohibited from purchasing or accepting delivery of alcoholic beverages from any source at any of Retailer's licensed locations from the date any violation occurs until all delinquent payment are paid in full.

(2) A prohibited purchase or acceptance of a delivery of alcoholic beverages is a violation of this section.

(h) Exception. A Retailer who wishes to dispute a violation of this section or inclusion on the commission's Delinquent List based on a good faith dispute between the Retailer and the Seller may submit a detailed electronic or paper written statement with the commission with an electronic or paper copy to the Seller explaining the basis of the dispute.

(1) The written statement must be submitted with documents and/or other records tending to support the Retailer's dispute, which may include:

(A) a copy of the front and back of the cancelled check of Retailer showing endorsement and deposit by Seller;

(B) bank statement or records of bank showing funds were available in the account of Retailer on the date the check was delivered to Seller; and

(C) bank statement or records showing:

(i) bank error or circumstances beyond the control of Retailer caused the check to be returned to Seller unpaid; or

(ii) the check cleared Retailer's account and funds were withdrawn from Retailer's account in the amount of the check.

(2) A disputed delinquent payment will not be removed from the delinquent list until documents and/or other records tending to support the Retailer's dispute are submitted to the commission.

(3) The Retailer must immediately submit an electronic notice of resolution of a dispute to the commission under this subsection.

(i) Penalty for Violation. An action to cancel or suspend a permit or license may be initiated under §11.61(b)(2) of the Code for one or more violations of this section. The commission may consider whether a violation is the result of an event or incident when initiating an action under this subsection.

(j) Delinquent List.

(1) The Delinquent List is published bi-monthly on the commission's public web site at http://www.tabc.state.tx.us. An interested person may receive the Delinquent List by electronic mail each date the Delinquent List is published by registering for this service online.

(2) Except as otherwise specified in subsection (k) of this section, the Delinquent List will be published on the fourth business day after the 25th day of the month for purchases made from the 1st to the 15th day of that month and for which payment was not made on or before the 25th day of that month. Except as otherwise specified in subsection (k) of this section, the Delinquent List will be published on the fourth business day after the 10th day of the next month for purchases made between the 16th and the last day of the preceding month and for which payment was not made on or before the 10th day of the month.

(3) The Delinquent List is effective at 12:01 A.M. on the date of publication.

(4) The Delinquent List is updated hourly to reflect reports of payments submitted.

(k) Calculation of Time. A due date under this section or §102.32(c) of the Code or the publication date of the Delinquent List that would otherwise fall on a Saturday, a Sunday, a state or federal holiday (unless the commission is required to be open for business), or a standard Federal Reserve bank holiday (as published

at http://www.frbservices.org/holidayschedules/index.html) will be the next regular business day. For purposes of this section, a business day means a day which is not a Saturday, a Sunday, a state or federal holiday (unless the commission is required to be open for business), or a standard Federal Reserve bank holiday (as published at http://www.frbservices.org/holidayschedules/index.html). A payment sent by U.S. postal service or other mail delivery service is deemed made on the date postmarked or proof of date delivered to the mail delivery service. A payment hand delivered to an individual authorized to accept payment on behalf of the Seller is deemed made when the authorized individual takes possession of the payment.

The amendment is authorized by Texas Alcoholic Beverage Code §5.31, which grants authority to prescribe rules necessary to carry out the provisions of the Code, and §102.32(f), which requires the commission to adopt rules to give effect to that section.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 29, 2013.

TRD-201300330
Martin Wilson
Assistant General Counsel
Texas Alcoholic Beverage Commission
Effective date: March 1, 2013
Proposal publication date: November 9, 2012
For further information, please call: (512) 206-3443

♦ ♦ ♦

TITLE 22. EXAMINING BOARDS

PART 5. STATE BOARD OF DENTAL EXAMINERS

CHAPTER 108. PROFESSIONAL CONDUCT
SUBCHAPTER E. BUSINESS PROMOTION

22 TAC §108.56

The State Board of Dental Examiners (SBDE) adopts new §108.56, concerning Certifications, Degrees, Fellowships, Memberships and Other Credentials, with changes to the proposed text as published in the December 7, 2012, issue of the *Texas Register* (37 TexReg 9590) and will be republished. The changes are due to public comment. Section 108.56 will be effective on May 1, 2013.

The SBDE's Advertising Rules Ad-Hoc Committee was convened to update the agency's advertising rules based on emerging technologies and issues in the business promotion of dentistry and dental practices. The committee met on August 4, 2011; October 7, 2011; November 10, 2011; January 27, 2012; March 9, 2012; and July 13, 2012. SBDE previously adopted new advertising rules, §§108.50 - 108.55 and §§108.57 - 108.63, in the December 7, 2012, issue of the *Texas Register* (37 TexReg 9637).

New §108.56 is adopted to protect the public from false, misleading or deceptive advertisement and to offer SBDE's licensees clear guidance as to restrictions on advertising.

One public comment was submitted by the Texas Academy of General Dentistry (TAGD) in response to the proposed text.

The comment requested clarification of the permitted placement of abbreviated credentials in an advertisement. SBDE modifies the rule to make clear that abbreviated credentials may not be on the same line as the dentist's name and designation as a dentist.

The comment addressed subsection (d) of the proposed rule and recommended SBDE clarify the term "dissemination to the public." SBDE agrees and modifies the rule in response to public comment. TAGD also suggested the inclusion of correspondence with existing patients of record in the exemption allowed by the subsection. SBDE maintains the language as proposed to protect prospective and current patients from potentially misleading communications.

The comment requested SBDE provide additional time to allow dentists to come into compliance with the rule. SBDE agrees. The adopted rule will be effective on May 1, 2013, and SBDE staff have been directed to delay enforcement of the rule until September 2, 2013.

The new section is adopted pursuant to Texas Government Code §§2001.021 et seq. and Texas Occupations Code §254.001, which authorize the SBDE to adopt and enforce rules necessary for it to perform its duties.

The adoption of the new rule affects Texas Occupations Code, Title 3, Subtitle D and Texas Administrative Code, Title 22, Part 5.

§108.56. Certifications, Degrees, Fellowships, Memberships and Other Credentials.

(a) Dentists may advertise credentials earned in dentistry so long as they avoid any communications that express or imply specialization in a recognized specialty, or specialization in an area of dentistry that is not recognized as a specialty, or attainment of an earned academic degree.

(b) A listing of credentials shall be separate and clearly distinguishable from the dentist's designation as a dentist. A listing of credentials may not occupy the same line as the dentist's name and designation as a dentist. Any use of abbreviations to designate credentials shall be accompanied by a definition of the acronym immediately following the credential.
Figure: 22 TAC §108.56(b)

(c) The provisions of subsection (b) of this section shall not be required in materials not intended for business promotion or public dissemination, such as peer-to-peer communications.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 4, 2013.

TRD-201300436
Glenn Parker
Executive Director
State Board of Dental Examiners
Effective date: May 1, 2013
Proposal publication date: December 7, 2012
For further information, please call: (512) 475-0977

♦ ♦ ♦

TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 3. LIFE, ACCIDENT AND HEALTH INSURANCE AND ANNUITIES

SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS

INTRODUCTION. The commissioner of insurance adopts amendments to 28 TAC Chapter 3, Subchapter X, Preferred Provider Plans, §§3.3701 - 3.3710, concerning the regulation of preferred provider benefit plans, and new §§3.3720 - 3.3725, concerning the regulation of exclusive provider benefit plans. The commissioner adopts the amendments to §§3.3702 - 3.3705, 3.3707 - 3.3709, and new §§3.3720 - 3.3725 with changes to the proposed text published in the November 2, 2012, issue of the *Texas Register* (37 TexReg 8690). Sections 3.3701, 3.3706, and 3.3710 are adopted without changes to the proposed text.

REASONED JUSTIFICATION. Amendments to Subchapter X are necessary to implement HB 1772, 82nd Legislature, Regular Session (2011), and to conform existing provisions of Subchapter X with HB 1772. HB 1772 amends Insurance Code Chapter 1301 to create exclusive provider benefit plans, which, under Insurance Code §1301.001(1), are benefit plans in which an insurer excludes benefits to an insured for some or all services, other than required emergency care provided by a physician or health care provider who is not a preferred provider.

The purpose of HB 1772 is to provide health insurers offering health plan coverage in Texas additional options to offer lower cost health plans to employers and individual consumers by permitting plans with closed networks where, as with health maintenance organizations, "only services provided by network providers are covered, with the exception of emergency services and out-of-network services provided when no network provider is available." *House Committee on Insurance, Bill Analysis, HB 1772, 82nd Legislature, Regular Session (2011).*

HB 1772 amends several sections of Insurance Code Chapter 1301, including §§1301.0041, 1301.0042, 1301.003, and 1301.005.

HB 1772 amends Insurance Code §1301.0041 and §1301.0042 to address applicability of Insurance Code Chapter 1301 and of insurance law in general to exclusive provider benefit plans. Under Insurance Code §1301.0041, an exclusive provider benefit plan is subject to Insurance Code Chapter 1301 in the same manner as a preferred provider benefit plan, unless the chapter specifies otherwise. Under Insurance Code §1301.0042, an insurance law that applies to a preferred provider benefit plan also applies to an exclusive provider benefit plan, except to the extent the commissioner determines the function is inconsistent with the function and purpose of an exclusive provider benefit plan.

HB 1772 also adds references to exclusive provider benefit plans to Insurance Code §1301.003 and §1301.005(b). The amendment to Insurance Code §1301.003 provides that an exclusive provider benefit plan that meets the requirements of Insurance Code Chapter 1301 is not unjust under Insurance Code Chapter 1701, unfair discrimination under Insurance Code Chapter 544 Subchapter A or B, or a violation of Insurance Code Chapter 1451 Subchapter B or C. The amendment to Insurance Code §1301.005(b) provides that an insurer must reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider and services were not available through a preferred provider within a designated service area under the exclusive provider benefit plan.

The department has taken Insurance Code §§1301.0041, 1301.0042, 1301.003, and 1301.005 into consideration in preparing the rule text adopted through this order. The department amends rule provisions that previously contemplated only preferred provider plans as necessary to make them applicable to exclusive provider benefit plans. The department also adopts new sections that are necessary to address the specific function and purpose of exclusive provider benefit plans and implement statutes that apply differently or exclusively to exclusive provider plans. These amendments are necessary to ensure that exclusive provider benefit plans meet the requirements of Insurance Code Chapter 1301, as contemplated by Insurance Code §1301.003.

HB 1772 also adds several new sections to Insurance Code Chapter 1301. These include Insurance Code §§1301.0051, 1301.0052, 1301.0053, 1301.0056, and 1301.1581. These new sections contain provisions applicable specifically to exclusive provider benefit plans. Insurance Code §1301.0051 addresses quality improvement and utilization management. Insurance Code §1301.0052 addresses referrals for medically necessary services. Insurance Code §1301.0053 addresses emergency care. Insurance Code §1301.0056 addresses examination and fees. Insurance Code §1301.1581 addresses information concerning exclusive provider benefit plans. Amendments to existing rule sections and new rule sections are necessary to implement these sections to establish processes and procedures for exclusive provider benefit plan compliance with Insurance Code Chapter 1301.

The department adopts the amended and new sections under and in order to implement Insurance Code §§1301.003, 1301.007, 1301.0042, and 1301.0055. Insurance Code §1301.003 permits exclusive benefit plans that meet the requirements of Insurance Code Chapter 1301. Insurance Code §1301.007 authorizes the commissioner to adopt rules to implement Insurance Code Chapter 1301. Insurance Code §1301.0042 provides that a provision of the Insurance Code or other insurance law that applies to a preferred provider benefit plan also applies to an exclusive provider benefit plan unless the provision is determined to be inconsistent with the function and purpose of an exclusive provider benefit plan. Insurance Code §1301.0042 also authorizes the commissioner to determine whether a provision is inconsistent with the function and purpose of an exclusive provider benefit plan.

Under Insurance Code §1301.0042, the department also adopts the amended and new sections to implement statutes applicable to preferred provider benefit plans as is consistent with the function and purpose of an exclusive provider benefit plan, including Insurance Code §§1301.0055, 1701.055, 1201.006, 1201.101 - 1201.102, 1251.008, 1456.006, 1456.003, and 1501.010 as those sections apply to exclusive provider benefit plans.

Insurance Code §1301.0055 requires the commissioner to adopt by rule network adequacy standards adapted to local markets to ensure availability of and accessibility to a full range

of contracted physicians and health care providers and, with good cause, may allow departure from local market network adequacy standards if the commissioner posts on the department's website the name of the preferred provider plan, the insurer offering the plan, and the affected local market.

Insurance Code §1701.055 permits the department to disapprove an insurance form if it violates the Insurance Code or a rule of the commissioner or any other law, contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive.

Insurance Code §1201.006 permits the commissioner to adopt reasonable rules as necessary to implement Insurance Code Chapter 1201. Insurance Code §1201.101 and §1201.102 permit the commissioner to adopt rules specifying the content of an individual accident and health insurance policy and to prohibit provisions in individual accident and health insurance policies that the commissioner determines to be unjust, unfair, or unfairly discriminatory.

Insurance Code §1251.008 permits the commissioner to adopt rules necessary to administer the group health insurance chapter of the Insurance Code.

Insurance Code §1456.006 permits the commissioner to adopt by rule specific requirements for the health benefit plan disclosure required under §1456.003.

Insurance Code §1501.010 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1501, the Health Insurance Portability and Availability Act.

In accord with Insurance Code §1301.0042(a), a provision of this code or another insurance law of this state that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan unless the department determines that the provision is inconsistent with the function and purpose of an exclusive provider benefit plan.

The department makes the following nonsubstantive changes to the proposed text as a result of comments. These changes do not affect persons not previously on notice or raise new issues.

Section 3.3702(b)(16)

The department revises the definition of "pediatric practitioner" as adopted in §3.3702(b)(16) to be "A physician or provider with appropriate education, training, and experience whose practice is limited to providing medical and health care services to children and young adults."

A commenter asks that the department revise the definition "pediatric practitioner" to reference advance practice nurses in addition to physicians. The department declines to make the requested change, because the definition only appears in §3.3707, in regard to waivers from network adequacy requirements. The provisions within the rule that relate to network requirements do not generally address specific provider types, but rather address "physicians or providers." So, for consistency with that usage, the department revises the definition "pediatric practitioner" to reference a "physician or provider."

Section 3.3703(a)(23)

The department amends the text of §3.3703(a)(23) as adopted to provide that in a contract provision under that section a referring physician or provider would need to disclose that the physician, provider, or facility to which the insured is being referred might not be a preferred provider. The department also revises the text to clarify that the requirement that a referring physician or provider disclose an ownership interest is only applicable if the referring physician or provider actually has an ownership interest in the provider to which the insured is being referred.

Two commenters ask that the department revise §3.3703(a)(23) and offer suggested new text.

The text offered by one commenter would revise the ownership interest disclosure language in §3.3703(a)(23) to require that a referring physician or provider disclose any financial interests the physician or provider has in the physician, provider, or facility to which the insured is being referred. It would also add a requirement for physicians and providers to give annual updates of financial interests in other physicians and health care providers. It would also define the term "financial interests."

The text offered by the other commenter would create a new section that prohibits insurers from: requiring providers to disclose financial interests, requiring that providers refer patients to preferred providers, or requiring that insureds sign documents acknowledging that a provider has a financial or ownership interest in a referred physician or health care provider.

The department declines to adopt either offered version. However, in partial response to one of the comments the department agrees to make a clarifying change to the paragraph.

Section 3.3703(a)(27) and (28) and the figure in §3.3705(f)(1)

The department amends §3.3703(a)(27) and (28) to except applicability of the paragraphs to emergency care. The department also revises the figure in §3.3705(f)(1) to clarify that the right to advance estimates only applies in most cases.

Three commenters ask that the department revise these provisions to exempt applicability of the paragraphs to emergency care because it is not feasible for an emergency care provider to provide advanced notices or estimates and to prevent confusion and avoid delays for insureds in emergency care situations. The department agrees in regard to §3.3703(a)(27) and (28). However, the department makes an alternative revision to the figure in §3.3705(f)(1), incorporating language that will address emergency situations and other situations where an insured may not be able to obtain advance estimates of out-of-network provider charges or insurer payment.

Section 3.3703(a)(27)(A) and (B) and §3.3703(a)(28)(A) and (B)

The department revises §3.3703(a)(27)(A) and §3.3703(a)(28)(A) to change the phrase "to coordinate the insured's care" to "for more information." The department revises §3.3703(a)(27)(B) and §3.3703(a)(28)(B) to delete the words "so that the insurer has the opportunity to coordinate the insured's care."

Several commenters voice concerns regarding §3.3703(a)(27)(A) and (B) and §3.3703(a)(28)(A) and (B). They say that the provisions are awkwardly worded or that they imply that the department intends to limit an insured's choice of provider, interfere with medical care, or create a duty for insurers to oversee the coordination of insureds' care.

In response to the comment, the department clarifies that the purpose of the provisions relates to advance information that could help insureds and insurers avoid balance billing, and the department revises the text of the provisions.

Section 3.3703(a)(29)

The department does not adopt proposed §3.3703(a)(29).

A commenter opposes adoption of proposed §3.3703(a)(29) on the grounds that it would limit the department's authority.

The department does not agree with the commenter's assessment that proposed §3.3703(a)(29) would limit the department's authority. However, the department agrees to withdraw the proposed paragraph on the basis that the provision is not necessary, and the department can regulate insurers and carry out the department's statutory responsibilities without it.

Section 3.3704(a)(1) and (11)

The department restructures the way exclusive provider benefit plans are addressed in the fairness provisions under §3.3704(a).

A commenter raises concerns that the exclusion under §3.3704(a)(1) addressing exclusive provider benefit plans would allow exclusive provider benefit plans to require insureds to have services performed by particular hospitals, physicians, or practitioners. The commenter also says the proposed amendment to §3.3704(a)(11) is overly broad, and one could read it as exempting exclusive provider benefit plans from having to make preferred provider benefits reasonably available to insureds within a designated service area. The commenter offers alternative text to address this concern.

The department does not agree with the comment regarding §3.3704(a)(1), but agrees to withdraw the proposed amendment to avoid confusion. The department agrees with the comment regarding §3.3704(a)(11) and adopts the alternative text the commenter suggests. This results in amendments to §3.3704(a) and in new §3.3704(b).

Section 3.3704(a)(12)

The department adds the word "reasonably" to §3.3704(a)(12).

A commenter asks that the department revise §3.3704(a)(12) by adding the word "reasonably."

The department agrees to the addition.

Section 3.3704(d)

The department revises §3.3704(d) as adopted to state that an insurer is prohibited from engaging in retaliatory action against an insured because the insured or a person acting on behalf of the insured has filed a complaint with the department or the insurer against the insurer.

A commenter asks the department to clarify in proposed §3.3704(c), which is adopted as §3.3704(d), that the prohibition under the subsection includes instances when the insured or a person acting on behalf of the insured files a complaint "with the department or the insurer."

The department agrees to add the clarification requested by the commenter.

Section 3.3705(b)(1)

The department revises proposed §3.3705(b)(1) to insert the phrase "and written description or as otherwise required by law" at the end of the paragraph.

A commenter recommends that the department modify the proposed language of §3.3705(b)(1) to ensure that the subsection would require an insurer to provide to consumers adequate information regarding their exclusive provider benefit plan coverage in its written description. The commenter suggests language to accomplish this.

The department agrees to the revision.

Section 3.3705(b)(14)

The department withdraws the proposed deletion of text in §3.3705(b)(14) and relocates the new text proposed for §3.3705(b)(14) to new §3.3705(b)(15).

A commenter supports retaining the text proposed for deletion in §3.3705(b)(14). The commenter points out that the demographic information disclosed under the paragraph could prevent unanticipated balance billing by informing consumers of the composition of insurers' networks, enabling consumers to assess the potential for balance billing.

The department agrees with the comment and withdraws the proposed deletion of text in §3.3705(b)(14). This necessitates redesignating the proposed amended text as a new paragraph.

Section 3.3705(f)(1) and (2)

The department revises the language of the figures in §3.3705(f)(1) and (2) to more closely track the statutory language.

Two commenters comment on the figures in §3.3705(f)(1) and (2). One commenter says that the language in the figure in §3.3705(f)(1) is confusing and asks the department to not adopt the figure. A second commenter suggests the department revise the language in the figures in §3.3705(f)(1) and (2) and suggests language to use.

The department uses part of the second commenter's suggested language in the figure in §3.3705(f)(1) and completely incorporates the second commenter's suggested language for the figure in §3.3705(f)(2).

Section 3.3705(l)(2) and (3)

The department withdraws its proposed deletion of §3.3705(l)(2) and (3). The department also revises §3.3705(l) to reference "the requirements in paragraphs (1) - (9)."

A commenter supports retaining the text proposed for deletion in §3.3705(l)(2) and (3), pointing out that deletion of the provisions would undermine the collective impact of the transparency provisions of §3.3705(l).

The department agrees with the comment and withdraws the proposed deletion of text in §3.3705(l)(2) and (3). For consistency with this change, the department also revises §3.3705(l) to reference "the requirements in paragraphs (1) - (9)."

Section 3.3705(m)

The department revises §3.3705(m) to require two additional pieces of information in an insurer's annual policyholder notice concerning use of a local market access plan, information on how any local market access plan or plans the insurer uses may be obtained or viewed, and a link to the department's website where the department posts information relevant to the grant of waivers.

A commenter suggests that the insurer's annual policyholder notice be improved to give insureds access to all relevant information on the waiver and local market access plan in one place. The commenter suggests that the notice should point insureds to two other important pieces of information: (1) how they can obtain or view the full local market access plan and (2) a link to TDI's web page on waivers that have been granted.

The department agrees with the commenter and incorporates the revision into the adoption order.

Section 3.3705(n)

The department withdraws its proposed deletion of §3.3705(n).

A commenter opposes the proposed deletion of §3.3705(n). The commenter says §3.3705(n) would aid consumers in decision making and reduce incidents of unanticipated balance billing. The commenter disputes arguments that disclosures under §3.3705(n) could be misleading in instances where decreases in the availability of network providers is temporary, noting that there is a low risk of insureds getting misleading information because the information required under the section is posted in online directories and can easily be updated. The commenter also points out that the requirement for updated provider listings under §3.3705(i) and (j) and the detrimental reliance provisions under §3.3705(k) would not provide sufficient consumer protection to outweigh the detriment caused by the loss of §3.3705(n).

In response to the comments, the department agrees to withdraw its proposed deletion of §3.3705(n).

Section 3.3705(p) and (q) and the text that was located in §3.3707(f)

The department withdraws its proposed deletion of §3.3705(p) and (q) and the text that was located in §3.3707(f), which is redesignated §3.3707(n) in the adopted text. The department revises the text of §3.3705(p) to only require plan designations on the outline of coverage and the cover page of any provider listing describing the network.

A commenter opposes the proposed deletion of §3.3705(p) and (q). The commenter says removal of these provisions would deprive insureds of the ability to investigate their insurance options. The commenter says that removal of the provisions would open the possibility for insurers to use unjust and deceptive forms. The commenter also says the requirement for updated provider listings under §3.3705(i) and (j) and the detrimental reliance provisions under §3.3705(k) would not provide sufficient consumer protection to outweigh the detriment caused by the loss of §3.3705(p) and (q). In addition, the commenter requests that the department retain the text that was located in §3.3707(f). This text references the requirements of §3.3705 (p) and (q), and the commenter says it is also important for insureds to understand limitations of their network.

The department withdraws its proposed deletion of §3.3705(p) and (q) and the text that was located in §3.3707(f), but revises the text of §3.3705(p).

Section 3.3707(i)

The department revises §3.3707(i) to include a time frame for a waiver request if the status of a network utilized in any preferred provider benefit plan changes so that the health benefit plan no longer complies with the network adequacy requirements specified in §3.3704.

A commenter requests that the department build reasonable time frames for payers to identify and address network gaps into §3.3707(i).

The department agrees with the commenter and revises §3.3707(i) to include time frames for payers to identify and address network gaps. As adopted, §3.3707(i) allows an insurer 90 days from the date a network becomes inadequate to file for a waiver. This gives insurers time to contract with providers to fix a network inadequacy and permits the consolidation and presentation of multiple waiver requests at the same time.

Section 3.3707(i)(1)

The department removes the requirement in §3.3707(i)(1) that an insurer's local market access plan must be made available to the department on request.

A commenter points out that provisions require insurers to file their local market access plans with the department and asks why, in light of those provisions, it is necessary to include the requirement in §3.3707(i)(1).

The department agrees that the requirement in §3.3707(i)(1) that an insurer's local market access plan must be made available to the department on request is redundant and does not include it in the adopted rule text.

Section 3.3708(b)(3)

The department removes the phrase "in excess of the allowed amount" from the text proposed for §3.3708(b) and inserts the words "charges for covered services that were above and beyond."

A commenter references the department's intent that under §3.3708(b), an insurer must credit the full amount paid by an insured to the insured's deductible and annual out-of-pocket maximum applicable to in-network services when the insured receives services from a nonpreferred provider and the insured pays a balance bill. The commenter says the department's description of the credit an insurer must give an insured is open to several interpretations and could result in different administration by different insurers. The commenter supports maintaining §3.3708(b) as it existed prior to the proposal, asserting that the previous text would better protect insureds who do not voluntarily choose to obtain services from nonpreferred providers by giving the insureds credit for their actual out-of-pocket expenses in the same manner they would receive credit if they had received services from a contracted preferred provider.

The department declines to withdraw the proposed amendment, and instead revises §3.3708(b) to clarify the ambiguity the commenter identifies.

Section 3.3724(d)

The department revises §3.3724(d) to provide that the nonconditional accreditation an insurer receives be "certification specific and germane to the insurer's quality improvement program."

A commenter recommends that the department modify §3.3724(d) to emphasize accreditations or certifications specifically tailored to the insurer's quality improvement program.

The department agrees with the commenter and revises §3.3724(d) using the commenter's suggested text.

The department makes the following non-substantive changes to the proposed rule text in addition to the changes made as a result of comments. These changes do not affect persons not previously on notice or raise new issues.

Necessary redesignation of provisions

The department redesignates subsections, paragraphs, and citations to subsections and paragraphs where necessary to conform with the changes the department made in response to comments.

Definition of "health care provider or provider" in §3.3702(b)(10)

As proposed, the definition of "health care provider or provider" in §3.3702(b)(10) references the definition of the term as defined by Insurance Code §1301.001(1). However, "health care provider or provider" is actually defined in Insurance Code §1301.001(1-a). The department revises §3.3702(b)(10) as adopted to include the correct citation.

Email addresses

In November 2012, all contact emails for department program areas changed from "[program area]@tdi.state.tx.us" to "[program area]@tdi.texas.gov." In accord with this change, all department program area email addresses in this adoption order have been updated to reflect the new domain.

Also, in conjunction with the domain name change, the Managed Care Quality Assurance (MCQA) office updated its email address. The MCQA was previously called the Health and Workers' Compensation Network Certification and Quality Assurance (HWCN) office. The HWCN office used the email address "hwcn@tdi.state.tx.us." The MCQA office continued to use this email address after its name change, until after the finalization of the domain name change. With the finalization of the domain name change, the MCQA office updated its email address to reflect its name. Accordingly, all references to hwcn@tdi.state.tx.us in the rule text are changed to mcqa@tdi.texas.gov.

Revisions for consistency with department style

The department has initiated a comprehensive overhaul of its writing style guidelines to ensure consistency, clarity, and conciseness in department rules. The department has made non substantive revisions to the adopted rule text to implement these changes, as follows.

The department makes the following changes to improve conciseness:

The department removes the words "that are" from the definition of "exclusive provider network" in §3.3702(b)(7). The department also removes the words "that are" from §3.3703(a)(8) and (11).

The department removes word "the" from in front of the words "termination of the contract" in §3.3703(a)(26). In addition the department removes the word "the" from in front of the words "Insurance Code" and "Health and Safety Code" in each instance where it appears in a citation to a specific part of those codes. The department only makes these revisions in provisions that were not labeled "no change" in the proposal.

The department changes the word "upon" to "on" in §3.3705(k) and (p), and §3.3725(e).

The department changes "such that" to "so" in the words "at the facility such that the" in §3.3705(n)(2)(A).

The department deletes the word "to" from the words "and to update its" in §3.3705(n)(5).

The department deletes the word "that" from the words "at the same time that" in §3.3707(d).

The department deletes the words "set forth" from the words "the standards set forth in" in §3.3709(b)(3).

The department deletes the word "a" from the words "as a part of the annual report," in §3.3709(c).

The department changes the word "accordance" to "accord" in §§3.3722(d)(7), 3.3723(f)(3), 3.3725(c)(3)(B).

The department makes the following changes to avoid use of passive voice:

The department revises the words "the information must identify how the local market access plan may be obtained or viewed" to "the information must identify how to obtain or view the local market access plan," in §3.3705(b)(15)(C).

The department revises the words "information concerning how a nonelectric copy of the listing may be obtained" to "information concerning how to obtain a nonelectric copy of the listing" in §3.3705(h).

The department revises the sentence "The insurer must ensure that all electronic or nonelectronic listings of preferred providers made available to insureds are updated at least every three months," to "The insurer must ensure that it updates all electronic or nonelectronic listings of preferred providers made available to insureds at least every three months," in §3.3705(h).

The department changes the words "information on how any local market access plan or plans the insurer uses may be obtained or viewed" to "information on how to obtain or view any local market access plan or plans the insurer uses" in §3.3705(m)(2).

The department changes the words "is required to" to "must" in §3.3705(n)(3), (n)(5), and (q); and §3.3708(e).

The department changes the words "is also required to" to "must also, "request for waiver" to "waiver request," and "the request is filed with," to "the insurer files the request" in §3.3707(d).

The department changes the words "must be in compliance with" to "must comply with" in §3.3722(e)(3).

The department changes the words "reports submitted by the insurer," to "reports the insurer submits" in §3.3723(f)(7).

The department makes the following changes for consistency with current department rule drafting style:

The department makes the word "Department" lowercase in §3.3705(n)(2)(B) and (4)(C).

The department adds a comma following the word "reasonable" in §3.3706(a) and to the dollar amount "$1000" in §3.3708(e).

The department changes the words "such response" to "the response" in two places and the word "shall" to "must" in one place in §3.3707(e).

HOW THE SECTIONS WILL FUNCTION. As adopted, Subchapter X relates to Preferred and Exclusive Provider Plans. The subchapter is separated into two divisions.

Division 1, relating to General Requirements, addresses general requirements applicable to both preferred provider benefit plans and exclusive provider benefit plans, unless otherwise indicated. Division 1 includes §§3.3701 - 3.3711.

Sections 3.3701 - 3.3711 address regulation of both preferred provider benefit plans and exclusive provider benefit plans. The sections specify minimum requirements for the content of a waiver request and strengthen review processes for local market access plans.

Section 3.3701 provides effective dates for the rules and also addresses applicability of other rules in Title 28 to exclusive provider benefit plans. The provisions in this section provide notice to insurers of the applicability and effective dates of the regulations under the subchapter and clarify certain limitations

on the scope of the amended subchapter. Under Section 3.3701, the subchapter applies to any preferred or exclusive provider benefit plan that is offered, delivered, or issued for delivery on or after 150 days from the effective date of the rules. However, the subchapter does not apply to an exclusive provider benefit plan regulated under 28 TAC Chapter 3, Subchapter KK (relating to Exclusive Provider Benefit Plan) written by an insurer under a contract with the Texas Health and Human Services Commission to provide services under the Texas Children's Health Insurance Program, Medicaid, or with the Statewide Rural Health Care System.

Section 3.3702 incorporates definitions for terms defined in Insurance Code Chapter 1301 and includes necessary definitions for terms used in the subchapter. The purpose of §3.3702 is to ensure consistent terminology throughout Subchapter X. As adopted, §3.3702 includes the following new defined terms: "adverse determination," "allowed amount," "complainant," "complaint," "exclusive provider network," "in-network," and "out-of-network." The adoption also amends the definitions of "pediatric practitioner" and "urgent care."

Section 3.3703 addresses current standards and requirements for contracting, enforcement of contracting standards and rights, and delegation of contracting to exclusive provider benefit plans, exclusive provider organizations, and health care collaboratives.

This adoption amends §3.3703(a)(23) to clarify the contract provision that addresses disclosure by a referring physician or provider regarding the preferred provider status of the physician, provider, or facility to which the insured is being referred and, if applicable, ownership interest in the provider that a patient is being referred to. Under the provision, all referring providers must disclose to insureds that the provider the insured is being referred to might not be a preferred provider. Also, providers referring to facilities they have an ownership interest in must disclose this.

Amended §3.3703(a)(27) and (28) establish contracting requirements that provide for notice to insurers and insureds in specific instances where a recommended or scheduled surgery may result in care being provided to an insured by an out-of-network provider.

Section 3.3704 addresses freedom of choice and availability of preferred providers. As amended, §3.3704 includes provisions addressing exemptions from the general requirements to the extent necessary to conform to the statutorily permitted structure of exclusive provider benefit plans.

Amended §3.3704(b), which is added in response to a comment, clarifies that an exclusive provider benefit plan is not considered unjust under Insurance Code §§1701.002 - 1701.005, 1701.051-1701.060, 1701.101 - 1701.103, and 1701.151; or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, or §§544.051 - 544.054; or to violate Insurance Code §§1451.101 - 1451.127 if it complies with the requirements of §3.3704(a)(1) - (10) and (12). For purposes of §3.3704(a)(11), an exclusive provider benefit plan must only ensure that preferred provider benefits are reasonably available to all insureds within a designated service area.

Amended §3.3704(d) includes a clarification that an insurer is prohibited from engaging in retaliatory action against an insured because the insured or a person acting on behalf of the insured has filed a complaint with the department or the insurer against the insurer or a preferred provider. The clarification also provides that an insurer is prohibited from engaging in retaliatory action against an insured because the insured or a person acting on behalf of the insured has appealed a decision of the insurer.

Section 3.3705 addresses insurer communications with and disclosures to insureds. As amended, §3.3705 includes clarifications and exemptions necessary to conform to the statutorily permitted structure of exclusive provider benefit plans.

Amended §3.3705 retains provisions in Subsections (b)(14), (l)(2) and (3), (n), (p), and (q) that the department had proposed to delete, including: requirements for annually updated network demographics for each service area, additional listing-specific disclosure requirements, information required in an annual policyholder notice concerning use of a local market access plan, disclosure of substantial decrease in the availability of certain preferred providers, plan designations, and loss of status as an approved hospital care network.

Section 3.3705(b)(14) addresses required information regarding network demographics related to the number of insureds in a service area, the number of specified provider types, and the number of preferred provider hospitals in a service area or region.

New §3.3705(b)(15) addresses required information regarding whether any waivers or local market access plans approved pursuant to §3.3707 apply to the plan.

Amended §3.3705(f) also addresses reliance by an insured on provider listings in certain cases, and includes language for a notice of rights under a network plan applicable to a preferred provider benefit plan and a notice of rights under a network plan applicable to an exclusive provider benefit plan.

Section 3.3706 addresses designation as a preferred provider, decision to withhold designation, termination of a preferred provider, and review of the process. As adopted, §3.3706 contains minor clarifications and revisions for consistency with department rule drafting style.

Section 3.3707 addresses waivers due to failure to contract in local markets.

Section 3.3707(b) specifies minimum required elements in a request for a waiver from network adequacy requirements, and §3.3707(c) requires that an insurer file a local market access plan at the same time the insurer submits a request for waiver. The commissioner will take the local market access plan into consideration in deciding whether to grant or deny a waiver request.

As adopted, §3.3707(d) - (f) address copies of waiver requests insurers send to providers and department posting of information relevant to the grant of a waiver, and adopted §3.3707(g) provides the processes for an insurer to apply to renew a waiver.

Section 3.3707(h) addresses expiration of a waiver.

Section 3.3707(i) provides the time frame for establishment of a local market access plan and the filing of a waiver request if the status of a network utilized in any preferred provider benefit plan changes so that the health benefit plan no longer complies with the network adequacy requirements specified in §3.3704.

Section 3.3707(j) - (m) incorporate provisions related to local market access plans.

Section 3.3707(n) retains text previously included in §3.3707(f) regarding insurer compliance with §3.3705(p) concerning designation as having a "Limited Hospital Care Network" when the

department grants the insurer a waiver concerning network adequacy requirements for hospital-based services.

Section 3.3708 addresses payment of certain basic benefit claims and related disclosures. Amendments the department adopts in §3.3708 address payment of claims when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured, add clarification to the section, and address inapplicability of the section to exclusive provider plans.

Amendments to §3.3708(b) provide that when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured, the insurer must pay the claim based on usual or customary charges. This requirement is based on and clarifies the provisions of Insurance Code §1301.005(b) and §1301.155(b), which require that claims in these circumstances be paid at the same level of reimbursement as for a preferred provider. It also is based on the requirement of Insurance Code §1301.005(a) that an insurer make out-of-network (basic level) benefits "reasonably available" to all insureds.

Amendments to §3.3708(b) also clarify that, when an insured receives services from a nonpreferred provider because no preferred provider is reasonably available and the insured actually pays a balance bill to the nonpreferred provider, the insurer must credit the full amount paid by the insured for charges for covered services that were above and beyond the allowed amount to the insured's deductible and annual out-of-pocket maximum applicable to in-network services.

New §3.3708(e) requires an insurer to provide notice on explanations of benefits that an insured may have the right to request mediation under Insurance Code Chapter 1467 and Chapter 21, Subchapter PP, when services are rendered to the insured by a nonpreferred provider.

Section 3.3709 addresses the annual network adequacy report. Amendments to the section removed provisions addressing local market access plans that are relocated to adopted §3.3707.

Section 3.3710 addresses failure to provide an adequate network. Amendments to §3.3710 address applicability to exclusive provider networks and update statutory citations.

New Division 2, relating to Exclusive Provider Benefit Plan Requirements, addresses requirements that are applicable only to exclusive provider benefit plans. It consists of new §§3.3720 - 3.3725.

New §3.3720 addresses applicability of Division 2. As previously noted, the division is only applicable to exclusive provider benefit plans.

New §3.3721 provides that an insurer may not offer, deliver, or issue for delivery an exclusive provider benefit plan prior to obtaining commissioner approval of the insurer's exclusive provider network for each service area where the plan will be offered. This requirement is necessary to ensure that an insurer has met network adequacy requirements prior to offering, delivering, or issuing for delivery an exclusive provider benefit plan in accord with Insurance Code §1301.0056(a), which provides that an insurer is subject to a qualifying examination of the insurer's exclusive provider benefit plan.

New §3.3722 sets forth filing requirements and specifies the content of the initial application for approval of an exclusive provider benefit plan. These requirements and procedures are necessary to ensure compliance with network adequacy requirements.

New §3.3722(a) requires an insurer seeking to offer an exclusive provider benefit plan to file an application for approval with the department. It also provides the web address for a form that an insurer may use to prepare the application.

New §3.3722(b) sets forth general filing requirements, including legibility requirements and copy requirements for the original application packet and for any revisions or supplements to the application packet.

New §3.3722(c) includes 12 elements that must be included with an application for certificate of compliance. These elements are: (i) a statement regarding whether the filing is for an original or modified certificate of compliance; (ii) the name and contact information for the insurer; (iii) the name and contact information of an individual point of contact regarding the application; (iv) an attestation regarding the accuracy and completeness of the application and stating that the network is adequate for the services to be provided under the exclusive provider benefit plan; (v) a description and map of the service area; (vi) a list of all plan documents and each document's associated form filing ID number or form number; (vii) the forms for physician and provider contracts or an attestation that the contracts comply with the requirements of Insurance Code Chapter 1301 and 28 TAC Chapter 3, Subchapter X; (viii) a description of the quality improvement program; (ix) network configuration information; (x) documentation that demonstrates the insurer's intent to provide emergency care services; (xi) documentation that the insurer maintains a reasonable complaint system; and (xii) notification of the physical address of all books and records required under subsection (d) of the section.

New §3.3722(d) includes requirements that apply during a qualifying examination. These requirements are: insurers must make available for review by the department documents relating to quality improvement; utilization management; network configuration, including executed contracts; credentialing files; written materials for prospective insureds that contain information about the network and how preferred and nonpreferred providers will be reimbursed under the plan; the policy and certificate of insurance; and the complaint log.

New §3.3722(e) addresses approval and notification requirements for any changes implemented by an insurer after the department has granted approval of a certificate of compliance. New §3.3722(e)(1) requires an insurer to file an application for approval with the department prior to making changes to network configuration that impact the adequacy of the network, expand or reduce an existing service area, or add a new service area. New §3.3722(e)(2) requires an insurer to file with the department changes in maps of service areas, forms of contracts, or network configuration information. New §3.3722(e)(3) provides that, before the department grants approval of a service area expansion or reduction application, an insurer must comply with the requirements of §3.3724 in existing and proposed service areas. New §3.3722(e)(4) requires that an insurer file with the department any information other than the information described in §3.3722(e)(2) that amends, supplements, or replaces the items required under subsection §3.3722(c) no later than 30 days after the implementation of any change.

New §3.3723 provides standards and requirements for examinations relating to exclusive provider benefit plans conducted by

the department. These requirements are necessary to ensure continued compliance with network adequacy standards.

New §3.3723(a) states that the commissioner may conduct an examination as often as the commissioner considers necessary, and it specifies that an examination be conducted at least once every five years.

New §3.3723(b) requires financial, market conduct, complaint, or quality of care exams to be conducted under Insurance Code Chapter 401, Subchapter B, relating to the examination of carriers; Insurance Code Chapter 751, relating to market conduct surveillance; and 28 TAC §7.83, relating to appeal of examination reports.

New §3.3723(c) requires an insurer to make books and records relating to its operations available to the department to facilitate an examination.

New §3.3723(d) requires an insurer to provide to the commissioner on request a copy of any contract, agreement, or other arrangement between the insurer and a physician or provider.

New §3.3723(e) allows the commissioner to examine and use the records of an insurer, including records of a quality of care program and records of a medical peer review committee, for examination and enforcement purposes.

New §3.3723(f) requires the insurer to make available for review by the department documents relating to quality improvement, utilization management, complaints, satisfaction surveys, network configuration information, credentialing files, and reports.

New §3.3724 establishes minimum standards and requirements for a quality improvement program for commercial exclusive provider benefit plans in accord with Insurance Code §1301.0051. The section is necessary to ensure availability, accessibility, quality, and continuity of care for insureds.

New §3.3724(a) requires an insurer to develop and maintain an ongoing quality improvement program designed to evaluate the quality and appropriateness of care and services. It also requires an insurer to pursue opportunities for improvement. New §3.3724(a)(1) - (5) prescribes minimum standards for the quality improvement program and provides that the program must include specified standards. The standards are that the insurer: (i) include a written description of the quality improvement program that outlines program organizational structure, functional responsibilities, and meeting frequency; (ii) include an annual quality improvement work plan that includes program areas as specified in the section and that is designed to reflect the type of services and the population served by the exclusive provider benefit plan in terms of age groups, disease categories, and special risk status; (iii) include an annual written report on the quality improvement program; (iv) implement a documented process for selection and retention of contracted preferred providers that complies with the credentialing requirements set forth in §3.3706(c); and (v) provide for a peer review procedure for physicians and individual providers.

New §3.3724(b) requires the insurer's governing body to appoint a quality improvement committee, approve the quality improvement program, approve an annual quality improvement plan, meet at least once a year to review reports of the quality improvement committee, and review the annual written report on the quality improvement program.

New §3.3724(c) requires the quality improvement committee to evaluate the overall effectiveness of the quality improvement program and sets forth delegation, collaboration, and multidisciplinary team requirements.

New §3.3724(d) provides that when reviewing an insurer's quality improvement program, the department will presume that the insurer is in compliance with statutory and regulatory requirements regarding the insurer's quality improvement program if the insurer has received nonconditional accreditation or certification specific and germane to the insurer's quality improvement program by the National Committee for Quality Assurance, the Joint Commission, URAC, or the Accreditation Association for Ambulatory Health Care. However, new §3.3724(d) also provides that if the department determines that an accreditation or certification program does not adequately address a material Texas statutory or regulatory requirement, the department will not presume the insurer to be in compliance with that requirement.

New §3.3725 provides minimum standards for emergency care services and services provided out-of-network when no preferred provider is available, claim payments, reimbursement rates, and reimbursement methodologies. New §3.3725 ensures an adequate process for insureds to obtain out-of-network services when necessary and ensures an adequate claims payment and reimbursement process.

New §3.3725(a) requires an insurer to fully reimburse a nonpreferred provider for emergency care services specified in the subsection at the usual and customary rate or at a rate agreed to by the insurer and the nonpreferred provider for emergency care services when an insured cannot reasonably reach a preferred provider, until the insured can reasonably be expected to transfer to a preferred provider.

New §3.3725(b) requires an insurer to, upon request of a preferred provider, timely approve a referral to a nonpreferred provider for medically necessary covered services when the services are not available through a preferred provider. It also requires an insurer to provide a review by a health care provider with similar expertise as the provider to whom a referral is requested prior to denying a requested referral.

The language of §3.3725 differs from §3.3708, the section that addresses similar requirements applicable to preferred provider benefit plans, in that the department has not incorporated requirements in §3.3708(b) relating to payments of out-of-network providers when no preferred provider is reasonably available. The department determined that the language in §3.3708(b) is unnecessary given the statutory requirements in Insurance Code §§1301.0052, 1301.0053, and 1301.155. Insurance Code §1301.0052 requires an issuer of preferred provider plan to fully reimburse a nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider for covered medically necessary services not available through a preferred provider. Insurance Code §1301.0053 requires an issuer of an exclusive provider plan to reimburse a nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider for the provision of emergency care services. Insurance Code §1301.155 requires an insurer of an exclusive provider plan to provide reimbursement for specified emergency care services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider.

New §3.3725(c) addresses insurer facilitation of an insured's selection of a nonpreferred provider when medically necessary covered services, excluding emergency care, are not available through a preferred provider. Section 3.3725(c) provides that if

an insurer chooses to facilitate an insured's selection of a nonpreferred provider under the subsection, the insurer must offer an insured a list of at least three nonpreferred providers with expertise in the necessary specialty who are reasonably available considering the medical condition and location of the insured. If the insured selects a nonpreferred provider from the list provided by the insurer, §3.3725(d) - (f) are applicable. If the insured selects a nonpreferred provider that is not included in the list provided by the insurer, then §3.3725(d) - (f) are not applicable and, notwithstanding §3.3708(f), the insurer must pay the claim in accord with §3.3708.

New §3.3725(d) provides that an insurer reimbursing a nonpreferred provider under §3.3725(a), (b), or (c)(2) must ensure that the insured is held harmless for any amounts beyond the copayment, deductible, and coinsurance percentage that the insured would have paid had the insured received services from a preferred provider.

New §3.3725(e) sets the process for an insurer to follow when determining that a claim from a nonpreferred provider under subsection (a), (b), or (c)(2) is payable. It specifies that the insurer issue payment to the nonpreferred provider at the usual and customary rate or at a rate agreed to by the insurer and the nonpreferred provider. The insurer must also provide an explanation of benefits to the insured along with a request that the insured notify the insurer if the nonpreferred provider bills the insured for amounts beyond the amount paid by the insurer. The section requires that the insurer resolve any amounts that the nonpreferred provider bills the insured beyond the amount paid by the insurer in a manner consistent with §3.3725(d).

New §3.3725(e) also permits the insurer to require in its policy or certificate issued to an insured that, if a claim is eligible for mediation under Insurance Code Chapter 1467 and 28 TAC Chapter 21, Subchapter PP (relating to Out-of-Network Claim Dispute Resolution), the insured must request mediation, but the rule prohibits the insurer requiring the insured to participate in a mediation. The section requires that the insurer notify the insured when mediation is available, specifies what amount should be taken into consideration in determining when mediation is available, and provides that the insurer may not require that the insured participate in mediation or penalize the insured for failing to request mediation. The provision also provides that the insurer is not responsible for any balance bill after the insurer requests that the insured initiate mediation and until mediation is requested.

New §3.3725(f) provides methodology for insurer calculation of reimbursements.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General

Comment: A commenter believes that consumers should have strong from balance bills. The commenter says that exclusive provider benefit plans, which are new to Texas, must have sufficient consumer protections, including protections from balance billing, clear consumer disclosures, and adequate networks.

Agency response: The department agrees with the comment. The adopted rules will provide safeguards to an insured being charged for receiving services from a nonpreferred provider because no preferred provider was reasonably available to the insured. The adopted rules provide insureds some certainty in their insurance coverage and their financial security in regard to exclusive provider benefit plans, the rules establish sufficient consumer protections, including clear consumer disclosures and regulations that will result in adequate networks.

Comment: A commenter emphasizes the commenter's support for the department's clarifications and amendments included in the rule proposal and the department's deletion of some of the numerous disclosure requirements in the rules. The commenter says that despite some concerns it has with the rules, they are a vast improvement over the previously adopted rules in terms of administrative obligations.

Agency response: The department appreciates the supportive comment. However, the department notes that it has withdrawn the proposed deletion of some of the disclosures required by the rules, based on other comments.

Comment: A commenter is disappointed with the proposed rules, describing them as following a misguided path that undercuts the previously adopted regulatory framework. The commenter says the rules will cause irreparable harm for consumers by reducing the value of products they have purchased and increasing their out-of-pocket expenses, and by allowing unjust and deceptive policies into the market.

The commenter says the department could easily avoid this harm if it would proceed with a more robust and consumer protective stance by retaining and implementing previously adopted rules. The commenter says that the proposed rules disregard objections of consumer advocates and include objectionable provisions from a withdrawn proposal, with yet more insurer-friendly provisions added. The commenter is disappointed its comments on the previous withdrawn proposal were not heeded.

The commenter says that to ensure HB 2256 and HB 1772 are properly adhered to and that Texas consumers receive value for their insurance premiums, the department should: (1) jettison the rule proposal in its entirety; (2) implement the preferred provider benefit plan rules the department adopted May 19, 2011; and (3) restart the rule development process for exclusive provider benefit plan rules, going back to the draft rules posted on the department's website on September 8, 2011.

Agency response: The department disagrees with the comment and declines to the suggested changes. The department considered all comments received on the proposal published on November 2, 2012, and the proposal withdrawn effective November 2, 2012.

The department does not agree that the adopted rules undercut the previously adopted framework. In the rule proposal, the department proposed deletion of some insurer disclosure requirements. However, based on other comments, the department has withdrawn its proposed deletion of the disclosure requirements in §3.3705(b)(14),which the department retains in new §3.3705(b)(15), and §3.3705(n). The department also retains a modified version of §3.3705(p) and (q), which were initially adopted May 19, 2011.

Further, in the adopted rules, the department integrates requirements that will result in stronger insurer networks of providers and services. For example, the department's amendments to §3.3707 implement a rigorous process requiring that insurers obtain waivers from the department for continued use of local market access plans and specify required elements that must be included in an insurer's request for waiver.

The department does not agree that the rule proposal should be jettisoned in its entirety. The adopted rules are not satisfactory

to all parties commenting. However, in these rules the department strikes a balance between opposed sides. Given the nature of the health insurance market, it is unlikely the department could propose rules that satisfy all stakeholders. If the department were to start over on a completely new rule proposal, the end result would still be a controversial adoption order with many opposing comments.

The department does not agree that it should merely implement the preferred provider benefit plan rules the department adopted May 19, 2011. The legislature has given the department the task of integrating exclusive provider benefit plans into the Texas market. Because of the related nature of preferred and exclusive provider benefit plans, that integration necessitates changes to the rules adopted May 19, 2011.

As previously noted, the department has withdrawn the proposed deletion of several provisions from the rules adopted effective May 19, 2011, based on stakeholder comments. Because those provisions will remain in the rules, some of the provisions regarding consumer protections that the commenter requested will be implemented.

The department does not agree that it should restart the rule development process based on the draft rules posted on the department's website September 8, 2011. Many parties have provided valuable effort and input into developing the rules beyond the September 8, 2011, draft. These contributions have resulted in improved regulations.

In addition, going back to the September 8, 2011, draft would not reduce the contentiousness of this rulemaking process. The department has undertaken the task of balancing opposed positions, and starting over where the rules were in September 2011 would not generate agreement among the stakeholders or negate the difficulty of the task.

Comment: A commenter says that the proposed rules miss the mark regarding consumer protection because they relieve health plans from the basic responsibility of providing robust networks. The commenter supports rules previously adopted in December of 2011, and the commenter is confused by the removal of disclosure provisions on the basis that they are not helpful to insureds.

The commenter feels that removal of disclosure provisions lessens the up-front proactive oversight of insurers' networks, and points out that previously the department said these disclosures were necessary. The commenter says that the department must regulate its licensees and certificate holders prior to any consumer harm arising, and that disclosures to consumers regarding the true character of a network and failure of a network to comply with regulatory standards is vital.

The commenter says that the proposed rules remove up-front accountability and place the burden of proof on insureds or address issues on the back end, such as through mediation. The commenter says that it is not necessary to choose between protections or delete disclosures in favor of mediation. The commenter suggests that the changes will benefit insurers who want to rush products to market.

Agency response: The department disagrees that the proposed rules miss the mark in regard to consumer protection by relieving health plans from the basic responsibility of providing robust networks. The adopted rules aim at ensuring that an insurer's network is adequate for the services to be provided.

The department agrees it should adopt certain disclosure provisions. As the department discusses in connection with comments on the specific provisions, the department withdraws the proposed deletion of the disclosure provisions in §3.3705(b)(14) and (n) and retains a modified version of (p) and (q).

Comment: A commenter says that despite the department's acknowledgment that those commenting on the department's previous, withdrawn rule proposal were concerned that the withdrawn proposal relaxed requirements for insurers and diluted insurer reporting provisions, the content of the proposal published on November 2, 2012, does little or nothing to address those concerns.

The commenter says that the only significant changes in the new proposal are an attempt to provide a rational and defensible justification for amendments to the rules adopted May 19, 2011, and introduce new insurer-friendly provisions. It is wasteful and devoid of any rational or legitimate justification to amend previously adopted rules that were the result of years of work, deemed necessary by the department, and were never permitted to be implemented.

The commenter says the department fails in its legal responsibility to demonstrate in a clear and logical fashion that adoption of the proposed sections is a reasonable means to a legitimate objective. There is nothing reasonable about dilution of network adequacy requirements under a guise of alignment of statutes, or anything legitimate about pursuing insurer-friendly objectives when the department has acknowledged the necessary and proper nature of the previously adopted rules.

The commenter asserts that the purpose of the rule proposal is to provide insurers with the opportunity to dismantle previously adopted rules at the expense of Texas consumers, and the fact that comments on the withdrawn rule proposal incorporated in the new proposal were primarily those of insurers supports this view. The department's general statements regarding the need for the proposal published on November 2, 2012, were unsupported conclusory statements lacking the substance necessary to explain the department's deference to the insurance industry's recommendations or meet the department's ultimate statutory burden to provide a reasoned justification for the proposal.

Agency response: The department disagrees with the comment and declines to make a change based on it.

After reviewing comments on the prior proposed rules, the department determined that it was necessary to make substantive revisions to the proposed rules to address network adequacy concerns and consumer protection from balance billing.

Specifically, to address concerns regarding network adequacy, the department revised its proposal for §3.3707 to require that a waiver must be granted for an insurer to continue to use a network access plan. The proposed revisions to §3.3707 also make the waiver process more rigorous by requiring additional detailed information to justify the need for a waiver to use an access plan.

No insurer requested that the department require an insurer with an inadequate network to obtain a waiver from the department for continued use of a local market access plan. No insurer asked the department to impose additional requirements for the granting of a waiver.

In addition, the department proposed additions to the contracting requirements under §3.3703(a) to require notice to insurers and insureds regarding surgery referrals, to warn insureds about the possibility of a balance bill, and to enable an insurer to negotiate a rate with the referred provider to prevent a balance bill.

These changes impose new requirements on insurers not included in the withdrawn proposal, and would likely have been impermissible substantive changes if not introduced in a new proposal. However, the department believes the changes will lead to stronger networks, reduced reliance by insurers on access plans, and reduced instances of balance billing.

The department appreciated the comments it received on the withdrawn proposal, and used them in preparing the new proposal. The department did not rely on the comments from any one commenter or any one group of stakeholders. As an example of changes made based on comments on the proposal withdrawn effective November 2, 2012, the proposal published on November 2, 2012, §3.3725 incorporates changes to clarify that an insurer may not require that an insured participate in a mediation requested under Insurance Code Chapter 1467 and 28 TAC Chapter 21, Subchapter PP, or penalize an insured for failing to request a mediation.

Comment: A commenter says that the department's statement regarding the necessity of conforming amendments to the proposed rules is not supported by the facts or the underlying law. The preamble of the proposal relies on references to alignment to justify reaching into previously adopted preferred provider benefit plan rules to promulgate exclusive provider benefit plan rules. The department has previously used the alignment rationale, but the commenter has repeatedly challenged this justification and continues to disagree with the idea that the current proposal is necessary to align or confirm existing rule provisions.

The commenter says these arguments demonstrate that the proposal fails to constitute a reasonable means to amend or implement the preferred and exclusive provider benefit plan network adequacy requirements under HB 2256 and HB 1772.

The commenter raises four points against the department's justification for the rule proposal based on alignment of preferred and exclusive provider benefit plan rules.

First, the commenter says it is unnecessary to adopt rules addressing both preferred and exclusive provider benefit plans, because the department could achieve alignment through separate, stand-alone rules.

The commenter says alignment of the exclusive provider benefit plan rules was already happening before the department suspended implementation of its previously adopted preferred provider benefit plan rules and began proposing new rules. In 2011, the department made a working draft of exclusive provider benefit plan rules available that created a separate, stand-alone subchapter. That draft aligned exclusive and preferred provider benefit plans by largely tracking many of the provisions applicable to preferred provider benefit plans, with modifications to address incompatibilities.

The commenter says the posting of the initial draft made it clear the department initially intended independent rules. This shows it is unnecessary to adopt rules that address both preferred and exclusive provider benefit plans, and the commenter questions why the department would change this approach. The commenter suggests that the department decided to combine the rules at the insistence of the insurance industry.

Second, the commenter says aligning the preferred and exclusive provider benefit plan rules does not result in administrative simplification. Instead, the result is administrative complication.

The commenter says the proposed rules make it difficult to determine the applicability of specific provisions. As an example, the commenter points to §3.3701(f) and §3.3703(a)(1). Section 3.3701(f) says, "A provision of this title applicable to a preferred provider benefit plan is applicable to an exclusive provider benefit plan unless specified otherwise."

The commenter says the intent of §3.3701(f) must be to make every part of Division 1 that says "preferred provider benefit plan" read as if it also says "exclusive provider benefit plan." However, the term "exclusive provider benefit plan" appears in §3.3703(a)(1) in the line "A contract between a preferred provider and an insurer may not restrict a physician or health care provider from contracting with other insurers, preferred provider plans, preferred provider networks or organizations, exclusive provider benefit plans, exclusive provider networks or organizations, health care collaboratives, or HMOs."

The commenter says that, given §3.3701(f), use of the term "exclusive provider network" in §3.3703(a)(1) is redundant, makes one question whether the rest of §3.3703 is applicable to exclusive provider benefit plans, and is a misstep that casts doubt on the applicability of other sections to exclusive provider benefit plans. The commenter does not understand why the department would inject such a level of uncertainty and confusion into its rules.

The commenter also asks why the department was willing to create a separate division to address requirements solely applicable to exclusive provider benefit plans, yet not put all exclusive provider benefit plan requirements in a single division. As proposed, the rules will require people to flip between two divisions to determine all requirements for exclusive provider benefit plans. The commenter suggests the department may have decided to take this approach based on comments an insurance industry representative organization submitted in response to the department's request for comments on its informal working draft rules.

The commenter says that even if the department did consider comments from the insurance industry in organizing the preferred and exclusive provider benefit plan rules, it was not necessary. The structure of the rules does not relieve the insurance industry of its administrative or compliance burden. However, a proposal with aligned rules does give the insurance industry a chance to attack network adequacy standards for both preferred and exclusive provider benefit plan at the same time. If the department did not intend this, it should withdraw the proposed rules.

Third, the commenter says the rule proposal makes substantive amendments that are not merely conforming, as stated in the proposal preamble.

The commenter says the proposal makes numerous substantive changes to the preferred provider benefit plan rules that weaken them and are unnecessary and contrary to statements the department made when originally adopting them. The changes will also benefit insurers to the detriment of consumers by forcing consumers to seek care out-of-network and pay out-of-pocket for care.

The commenter says that substantive changes include deletion of insurer disclosure requirements in §3.3705(b)(14), (n), (p), and (q).

The commenter says the rule proposal could not actually be intended for alignment, because strong network requirements

are necessary to protect consumers in exclusive provider benefit plans. If alignment were necessary, the result would be increased, not decreased network adequacy requirements.

Fourth, the commenter says that the proposed rule takes an opposite approach to the statutory mandate. The commenter would not be opposed to alignment if the department did it in a manner consistent with law, but true alignment would result in few if any changes to the preferred provider benefit plan rules. The commenter points out that under Insurance Code Chapter 1301, exclusive provider benefit plans must comply with laws applicable to preferred provider benefit plans. The proposed rules take an opposite approach, by dragging preferred provider benefit plan rules down to accommodate exclusive provider benefit plans.

The commenter urges the department to instead bring exclusive provider benefit plans up to existing preferred provider benefit plan standards. This would ensure that exclusive provider benefit plans offer some value to consumers and also reduce the potential of preferred provider benefit plans becoming a type of "junk policy."

Agency response: The department disagrees with the comment and declines to make a change based on it. However, the department notes that in response to other comments it has withdrawn the proposed amendments to §3.3705(b)(14) and (n) and retained a modified version of (p) and (q), which contain the insurer disclosure requirements referenced by the commenter.

Alignment of the preferred and exclusive provider benefit plan rules is necessary. Just as the legislature made exclusive provider benefit plans a subset of preferred provider benefit plan products by addressing them in Insurance Code Chapter 1301, the chapter that addresses preferred provider benefit plans, and making them subject to preferred provider benefit plan statutory requirements, the department has incorporated exclusive provider benefit plans into the preferred provider benefit plan rules with specific exceptions.

To accommodate exclusive provider benefit plans into 28 TAC Chapter 3, a number of changes to the preferred provider rule are necessary. As addressed separately in this preamble, the department has reassessed the changes made in the rule proposal and has determined that some proposed changes are not necessary at this time.

In regard to the first point, the department agrees that alternatives exist to implement the statutes addressing preferred and exclusive provider plans, but it does not agree that it is bound to any one approach taken in an informal draft proposal. The department frequently uses informal draft rule text as a tool to explore regulatory options and involve stakeholders in rule development. Informal draft rules are clearly identified as subject to review and revision, and use of informal drafts does not restrict the ability of the department to fully develop regulations.

Factors the commenter cites regarding the initial informal draft illustrate the usefulness of the informal rule draft process. These factors demonstrate the appropriateness of integrating the rules applicable to preferred and exclusive provider benefit plans. The commenter notes that the informal rules for exclusive provider benefit plans largely tracked the preferred provider benefit plan rules. The department contends that this argument supports combining the rules. Rather than repeating nearly identical provisions in separate sections, the department made those provisions applicable to both preferred and exclusive provider benefit plans.

It is also appropriate that the rules addressing preferred and exclusive provider benefit plans be combined, because they are established by the same statutes, Insurance Code Chapter 1301. Under Insurance Code §1301.0042(a), a provision of the Insurance Code or another insurance law of Texas that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan, except to the extent that the commissioner determines the provision to be inconsistent with the function and purpose of an exclusive provider benefit plan. Because the laws are equally applicable to both preferred and exclusive provider benefit plans, it is appropriate that the department's regulations address them together, unless there is a specific need to address them separately.

In regard to the commenter's second point, the department does not agree that aligning rules for preferred and exclusive provider benefit plans results in administrative complication. As noted by the commenter in support of the commenter's first argument, many rule provisions are equally applicable to both preferred and exclusive provider benefit plans.

The department does not agree that §3.3701(f) demonstrates an example of administrative complication. Section 3.3701(f) does not specifically address how a person should read Division 1; it implements Insurance Code §1301.0042(a) by equating the term "exclusive provider plan" with "preferred provider plan" wherever that term appears in Title 28 of the Texas Administrative Code. This does not mean that the phrase "exclusive provider benefit plan" cannot be used separately in Title 28.

The department does not agree that the need to "flip between" two divisions within a chapter creates a burden. A thorough implementation of the exclusive and preferred provider statutes necessitates more than one section. Regardless of whether the sections are in a single division or divided between two divisions, a person must go between them to see the complete regulation.

In regard to the commenter's third point, the department notes that substantive changes within a rule proposal do not prevent adoption of the rule. A primary purpose of publishing a rule proposal is to notify interested parties of substantive changes an agency proposes to make to a rule. The bar against substantive changes arises when the agency prepares its adoption order. If an agency adopts rule text that is substantively changed from text the agency proposed, an interested party might not have sufficient notice as required by Government Code §2001.023 and §2001.024. The department withdrew its initial proposal and filed a proposal published on November 2, 2012, to comply with the notice requirements of these sections.

For these rules, the department filed all rule text with the Secretary of State and included all elements of a rule proposal, as required by Government Code §2001.024. The department filed notice of its proposed rule text twice, because the department decided to make changes to the text included in the first rule proposal and wanted to ensure that all interested parties had sufficient notice of the changes.

The department also notes that it has withdrawn the proposed amendments to all the specific subsections cited by the commenter, in response to other comments from the commenter.

In regard to the commenter's fourth point, the department does not agree that the rules take an opposite approach to the statutory mandate. In support of its argument, the commenter says that the proposed rules drag requirements for preferred providers down to accommodate exclusive providers. However,

these rules impose stricter network adequacy requirements on both preferred and exclusive provider benefit plans.

Under the previous rules, access plans were not so closely tied to the waiver process. Under the adopted rules, insurers under all plans must obtain a waiver in order to continue to market their products in areas with inadequate networks. The new rules also establishes detailed requirements for waiver requests.

Section 3.3707(a) and (i) address situations where an insurer's network fails to meet network adequacy requirements. Under these provisions, an insurer must obtain a waiver from the department to use a local market access plan.

Section 3.3707(a) now also specifies the minimum contents of an insurer's waiver request. Under that section, if an insurer wants to include in its network an area where providers or physicians are available but the insurer has failed to contract with them, the insurer must provide specific information about the insurer's attempts to contract with providers, the insurer's cost savings from not contracting, and steps the insurer will take to improve the insurer's network to avoid the need for future waivers.

The department believes these new requirements will improve network adequacy and benefit consumers in both preferred and exclusive provider benefit plans.

Comment: A commenter references the department's explanation for proposing amendments to the rule text a second time, rather than just adopting the rule text based on the department's initial proposal. The commenter says the department's statements are not supported by the changes to text made in the proposal published on November 2, 2012.

The commenter says the changes to text in the November 2, 2012, rule proposal do not require insurers to have complete networks and does not limit insurer reliance on alternatives to complete networks which provide only limited protections from balance billing. The text of the proposal published on November 2, 2012, only contains a few "insurer-friendly" changes from the text the department initially proposed. The commenter asserts that the changes actually weaken previously adopted network adequacy requirements.

To support this point, the commenter references a proposed clarification the department added to the contracting requirements in §3.3707(a)(29). The commenter also notes that the department simultaneously struck "a 'catch-all' provision previously adopted to aid in the regulation of insurers with regard to local market access plans."

The commenter then provides a bullet list of issues that demonstrate how the department has an apparent lack of intent to require insurers to provide complete networks to insureds. The list includes the following issues: permitting insurers to use indirect contracts with physicians to establish secret preferred provider organizations consumers cannot use to plan care; not establishing exclusive provider benefit plan certification requirements, as was contemplated at one point in an informal draft rule; removing important marketing incentives by deleting consumer disclosures; weakening department oversight by removing notifications plan insurers must provide to the department regarding reduction of network providers; and reducing the burden on insurers seeking waivers from network adequacy requirements by making it difficult for doctors to refute insurer assertions.

The commenter says these issues make it clear the department did not propose new rule text on November 2, 2012, to require insurers to have more complete networks.

The commenter says the department should adopt a regulatory framework that requires insurers to create and maintain complete networks, requires insurers to be transparent with consumers regarding the relative strength or weakness of their networks, and provides reasonable remedies if consumers are victims of an insurer's failure to provide an adequate network or updated information on its network.

The commenter says the department has failed to build this necessary framework, and that in fact it has deleted requirements that would support the framework, including disclosure of a substantial decrease in facility-based providers, disclosure of Approved Hospital Care Network status, and disclosure of loss of Approved Hospital Care Network status. The commenter then focuses on the detrimental reliance provision of §3.3705(k) to protect consumers from harm in the absence of these provisions, asserting that §3.3705(k) is only a limited protection from balance billing, that the department apparently over-estimates how many consumers will take advantage of the provision, and that the detrimental reliance provision alone is insufficient for consumer protection.

The commenter also says that the rules in the proposal published on November 2, 2012, reflect a department desire to push insureds into mediation of balance bills. However, adopting a preference of mediation over consumer disclosure provisions creates a false dichotomy. Providing up-front notice and maintaining mediation as a back-end measure for reducing impact would create the most comprehensive framework for consumer protection.

The commenter says the push to back-end remedies in the November 2, 2012, proposal text is clearly inconsistent with the department's statement that the rules are intended to limit insurers' reliance on alternatives to complete networks that provide only limited protections from balance billing.

Agency response: The department disagrees with the comment and declines to make a change based on it. However, the department has withdrawn the proposed deletion of requirements related to disclosure of substantial decrease in facility-based providers, disclosure of Approved Hospital Care Network status, and disclosure of loss of Approved Hospital Care Network status.

The department re-proposed the rule text because of substantive changes proposed for §§3.3703, 3.3707, and 3.3709.

The additional changes the department proposed for §3.3707 and §3.3709 in the proposal published November 2, 2012, will limit insurers' reliance on alternatives to complete networks by imposing restrictions on the waiver and local market access plan process.

Under the initial rule proposal, the department did not specify what information an insurer would need to provide to the department to show good cause for the department to grant a waiver from network adequacy requirements. In addition, the initial rule proposal did not require that an insurer secure the grant of a waiver for an insurer's continued use of a local market access plan.

Under the proposal published on November 2, 2012, the waiver and local market access plan processes are integrated in §3.3707. If an insurer's network does not comply with the network adequacy requirements of §3.3704, the insurer must have a waiver to avoid a violation of the department's rules. This requirement also applies in regard to local market access plans.

If an insurer wants to continue to use a local market access plan to address an inadequate network, the insurer must file with the department a request for a waiver to use the plan.

To show good cause for a waiver, an insurer must provide specific information to the department. If the waiver is for an area where providers or physicians are available, an insurer seeking a waiver must describe attempts to contract with providers or physicians, cost savings from not contracting, and steps the insurer will take to improve the insurer's network to avoid the need for future waivers. The department will take this information into consideration in determining if good cause exists for the waiver.

The additional changes the department proposed for §3.3703 on November 2, 2012, would establish contracting provisions that require provider notice to insurers and insureds in specific instances where a recommended or scheduled surgery may result in an insured receiving care from an out-of-network provider. The purpose of this change was to add an up-front notice to insureds and insurers regarding the possibility of out-of-network care and resulting balance bills.

In addition to the substantive changes in §§3.3703, 3.3707, and 3.3709, the department makes nonsubstantive revisions to the text the department included in the November 2, 2012, rule proposal. These changes clarify points in the initial proposal text and implemented revisions based on comments the department received on the initial text.

The change to §3.3703(a)(29) was one of these clarifications. In the initial proposal, the department proposed new §3.3707(a)(29), which provided: "This subsection does not prohibit other contractual provisions allowed by law." In the proposal published on November 2, 2012, the word "allowed" is changed to "not prohibited." The change was a nonsubstantive change, made to clarify that the provision did not create a prohibition where prohibitions were not otherwise created under law. The department has removed this paragraph in response to another comment.

The "catch-all" the commenter notes was a provision stating, "The department may request additional information necessary to assess the local market access plan." The department believes a requirement for insurers to provide specific information, as set out in the proposed rule, will better aid the department in reviewing network adequacy than a general statement that the department may request additional information.

The issues in the commenter's list are not things the department added or revised in the proposal published November 2, 2012.

The department's proposed deletion of §3.3705(b)(14), (n), (p), and (q) was included in the initial proposal, not added in the November 2, 2012, rule proposal. As such, these do not support an assertion that the changes in the department's text weaken network adequacy requirements. The department has also withdrawn the proposed deletion of §3.3705(b)(14), (n), (p), and (q) in response to other comments by the commenter.

All other issues the commenter includes in the list, as well as the commenter's concerns regarding §3.3705(b)(14), (n), (p), and (q) and the commenter's opposition to the department's reliance on §3.3705(k), are repeated and addressed in more detail elsewhere in this preamble in response to additional comments from the commenter on specific sections of the rule proposal.

Comment: A commenter addresses the difference between health maintenance organizations, preferred provider benefit plans, and exclusive provider benefit plans regarding payments. The commenter says that statutorily, health maintenance organizations must hold an enrollee harmless, while under a preferred provider benefit plan an insured may have different required coinsurance amounts based on whether the insured goes to an in-network or out-of-network provider. However, the commenter says, an insured covered under an exclusive provider plan should have only one level of coinsurance, which only applies if the insured goes to an in-network provider. The commenter says the department needs to clarify this concept in the rule.

Agency response: The department agrees that exclusive provider befit plan products generally only have one level of coinsurance. The department construes the coinsurance applicable to in-network providers as equating to the preferred level of benefits in a preferred provider benefit plan product.

Comment: A commenter applauds the department for its work on the proposed rules. The commenter says the rules will provide substantial benefit to patients, ensuring they receive the adequate networks they deserve. The commenter notes that the proposed additional requirements for waivers strengthen the rules' requirements that insurers provide adequate networks.

The commenter also references the provisions in §3.3708(B) and §3.3725 that address insurer reimbursement for services provided by a nonpreferred provider when a provider is not available in the insured's preferred or exclusive provider benefit plan's network. The commenter says that these provisions will provide valuable stimulus for plans to negotiate the contracts that create network adequacy and effectively address the issue of balance billing. The commenter says the provisions will also reverse a current incentive some plans have to refuse to negotiate with emergency providers.

Agency response: The department appreciates the supportive comment.

Comment: A commenter says the department has underestimated the cost of some of the requirements, because insurers will need to revise and re-file virtually all forms. The commenter says the estimate of two to 10 hours of administrative time is insufficient and the proposal does not address filing fees. The commenter believes that to assemble an exclusive provider benefit plan application, an insurer will require additional attorney and administrative staff time, for a total of at least 40-50 hours.

Agency response: The department disagrees with the comment and declines to make a change based on it.

The department does not agree that insurers will need to revise and re-file virtually all forms.

An insurer offering an exclusive provider benefit plan may satisfy most of the portions of the rule which require revisions to policy forms through the filing of a single document with the department in the nature of an endorsement containing the newly required elements.

Regarding additional expenses of the rule, the department believes that it has accounted for the expenses associated with the rule proposal.

The department based the cost note it included in the rule proposal on input received following a request for comments posted on the department's website. The department received general input on the cost of compliance, but did not receive specific cost estimates.

The department worked with the information available to identify categories of labor and cost of printing, copying, and mailing reasonably necessary to implement the proposed rules. The department also estimated hours of labor necessary to implement provisions, where possible, and acknowledged instances where expenses would vary from insurer to insurer.

The department also received one comment in response to the withdrawn proposal that addressed potential costs, and the department included this information in the cost note.

The department acknowledged that the commenter suggested the proposed rules could subject an insurer to filing fees, but that the commenter did not list specific forms and was unable to provide a cost estimate. The department also noted that the commenter suggested assembly of an exclusive provider benefit plan could total 40 to 50 hours.

In addition, because exclusive provider benefit plans are new products in Texas, costs for compliance with the rules will be a part of the overall cost of plan development, which is a result of the statute permitting insurers to establish exclusive provider benefit plans.

Comment: A commenter says that, because insureds covered by exclusive provider benefit plans cannot go out of network, network adequacy standards for exclusive provider benefit plans should be more stringent, and balance billing provisions should be more robust than they are for preferred provider benefit plans.

Agency response: The department disagrees with the comment and declines to make a change.

The network adequacy standards the department has adopted are largely the same for all network-based products, including health maintenance organizations and preferred and exclusive provider benefit plans. This permits administrative efficiencies for insurers and the department in reviewing networks that health benefit plan issuers will use with different products.

The department intends to strictly review all waiver requests insurers file for preferred and exclusive provider benefit plan networks. In regard to exclusive provider benefit plans, the rule provides additional protection for insureds receiving out-of-network care where no network provider is available.

Section 3.3725 requires that an insurer protect insureds from balance billing in situations addressed by the section. Thus, insureds will only be required to pay their coinsurance and co-payment in most situations addressed by §3.3725. This additional requirement for insurers offering exclusive provider benefit plans, which is similar to protections afforded enrollees in health maintenance organizations, provides sufficient protection for consumers while encouraging insurers to continually enhance network adequacy.

Section 3.3701

Comment: A commenter supports the proposed effective date. The commenter appreciates the department's willingness to provide sufficient time to implement the new requirements.

Agency response: The department appreciates the supportive comment.

Section 3.3702

Comment: A commenter recommends that the department modify the definition for "complaint" to allow for oral complaints and to address issues beyond coverage concerns. The commenter suggests revising the definition by including the words "oral or" beside every reference to "written complaint" in the definition and by expanding the definition to include communication to the insurer, not solicited by the insurer, concerning "the business practices of such insurer in this state."

The commenter also suggests a revision to proposed §3.3704(c), which is adopted as §3.3704(d), to add to the protection against retaliation by an insurer against an insured for making a complaint. The commenter suggests the department revise the section to state that the prohibition includes instances when the insured or a person acting on behalf of the insured files a complaint "with the department or the insurer."

Agency response: The department agrees in part and disagrees in part with the comment.

The department agrees the rule should clarify that insurers may not retaliate for complaints made to the department or the insurer. The department has revised §3.3704(d) as adopted to include the recommended change.

However, the department does not agree that the definition of "complaint" should include oral complaints, and the department declines to revise the definition of "complaint" as the commenter requests. Confirming accurate documentation of the specific content of an oral complaint is difficult, so the department would have limited ability to take action against an insurer based on an allegation of retaliation relating to an oral complaint.

Section 3.3702(b)(5) appropriately utilizes the definition of complaint found in §21.2502, a longstanding definition that both industry and the department are familiar with. The department has traditionally construed the language in §21.2502 "concerning coverage offered or issued" by an insurer to broadly apply to the insurance business practices of the insurer regulated by the department and not to be limited solely to coverage issues.

Comment: A commenter opposes the definition of "exclusive provider network" included in §3.3702(b)(7).

The commenter says that including a reference to indirect contracts in the definition greatly expands the number of contracts the department can consider in evaluating an insurer's network, which in turn reduces the insurer's burden to proactively and transparently maintain an adequate network. This is a departure from the direct contractual framework that should form the basis of the department's evaluation of networks and undermines transparency in insurer contracting. The commenter urges the department to consider the potential negative impact of including indirect contracts and asks that the department strike the word "indirectly" from the definition.

The commenter says that transparency is necessary so that consumers can make informed decisions, the department can oversee insurer compliance with rules, and providers can understand their contractual obligations.

The commenter says it cannot discern the rationale for broadening the definition and lessening insurer's network adequacy requirements and asks what consumer benefits result from an expansive definition for "exclusive provider network," or what is contemplated by the inclusion of indirect contracts.

The commenter says that even if the purpose of the department in including "indirectly contracted" language is to acknowledge an insurer's ability to enter into contracts with preferred provider organizations under Insurance Code §1301.061, the language is excessively broad. The definition in the rule would allow any

contractual relationship, no matter how remote or tenuous, to suffice in order to fulfill network adequacy requirements.

The commenter adds that even if the department intends to reference contracts under Insurance Code §1301.061, inclusion of those contracts would frustrate the purpose of promoting transparency for consumers. Contracts under Insurance Code §1301.061 have caused much confusion, and the department's "blessing" of them in the context of exclusive provider benefit plans will only add to that confusion. Allowing use of indirect contracts under exclusive provider benefit plans might confuse consumers by making it difficult for them to assess which providers are in or out of network. The commenter also says that networks established under Insurance Code §1301.061 are typically designed for the sole benefit of the insurers, not consumers.

The commenter also opposes the definition for "exclusive provider network" because it is not clear whether contracts insurers enter into under Insurance Code §1301.061 will be subject to meaningful oversight by the department.

The commenter says it is not clear how the definition for "exclusive provider network" will work with the definition for "preferred provider," because the definition for "preferred provider" only references providers who contract with insurers and does not address indirect contracts.

The commenter asks whether an insurer would be required to list all the indirectly contracted physicians in their provider listings. Insurers have not done so in the past, and this might be a regulatory loophole by which insurers could meet network adequacy standards while not providing complete provider listings to insureds.

In regard to this concern about a loophole, the commenter asks the following questions:

1) How does the consumer make informed decisions and plan to see an "indirectly contracted" physician, and thus utilize that plan benefit, if the indirectly contracted physician is not listed on the insurer's provider listing?

2) How does network composition like this, which is lacking in transparency, benefit the consumer (especially if contractual provisions creating out-of-network liability currently exist in many wrap network contracts)?

3) How does the preferred provider physician (a physician with a standard, direct contract) know whether he or she is making a referral to an exclusive provider network physician if only an "indirect contract" exists?

4) Will the department review and substantiate all of the "indirect contracts" when performing its analysis of the exclusive provider network's compliance with network adequacy standards?

5) How will the department evaluate and subsequently regulate compliance by the insurers who have these indirect arrangements?

6) How will the department ensure the value of the exclusive provider benefit plan product that is offered to consumers?

The commenter says that the broad inclusion of "indirect contracts" in the definition of "exclusive provider networks" would officially sanction rental networks that lease a provider's contracted rate. There is no clear regulatory mechanism to track or register those who lease a provider's rates or the contracts that allow the leasing of rates. It is unclear how the department would take those contracts into consideration when determining whether an exclusive provider benefit plan meets network adequacy requirements, substantiating the existence of the contracts, or otherwise applying the requirements in this proposal to the entities that lease a provider's contract rates.

The commenter concludes by asking that the department adopt a new section that would establish a registration process for preferred provider organizations. The commenter provides the following text for the proposed section:

Sec. 3.XXXX Registration required.

(a) Unless the person holds a certificate of authority issued by the department to engage in the business of insurance in this state or operate a health maintenance organization under Insurance Code Chapter 843, a person must register with the department not later than the 30th day after the date on which the person begins acting as a preferred provider organization as described by Insurance Code §1301.061 for an exclusive provider benefit plan.

(b) Notwithstanding Subsection (a), a preferred provider organization that holds a certificate of authority issued by the department to engage in the business of insurance in this state or is a health maintenance organization shall notify the commissioner that it is acting as a preferred provider organization on behalf of an exclusive provider benefit plan.

(c) A notification under Subsection (b) must be accompanied by a list of the insurer's or health maintenance organization's affiliates. The insurer or health maintenance organization shall update the list with the commissioner on an annual basis. A list of affiliates provided to the commissioner under this section is public information and is not exempt from disclosure under Government Code Chapter 552.

(d) Under subsection (a), a registration is required to include a list of all affiliates of the preferred provider organization. The list of affiliates provided to the commissioner under this section is public information and is not exempt from disclosure under Government Code Chapter 552.

Agency response: In regard to the commenter's concern that indirectly contracted physicians will not be included in the insurer's provider listing, the department notes that insurers must make provider directories available to consumers. This will enable consumers to see what providers are available, and a change in the description of contracts will not enhance this information. The department will not consider providers to be reasonably available to an insured if they are not listed in the directory.

Insurers must also show the department that the networks they rely on are sufficient to meet network adequacy requirements under §3.3704. If the insurer's contracts with providers the insurer relies on to show compliance are too remote or tenuous, the department will not find the network to be adequate. Finally, it is not the department's role to limit the terms an insurer and provider can agree to, except to the extent required by the Insurance Code or necessary for the protection of consumers and consistent with the Insurance Code.

The department has previously taken administrative actions when an insurer was unable to demonstrate that a provider had consented by contract or chain of contracts to permit discounts taken by the insurer. The department will continue to enforce this principle.

Use of indirectly contracted preferred provider organization networks has generally been more beneficial to insurers in the past in the context of a preferred provider benefit plan product, where the insurer is responsible for payment of out-of-network claims. In an exclusive provider benefit plan, the insurer will normally not be responsible for paying out-of-network claims, so there is less of a need to access additional networks. The department has not strictly required insurers to provide complete directories of all contracted providers or enforced strict network adequacy standards. Going forward, insurers will have a much greater incentive to provide complete directories, as the department will be reviewing these issues more closely.

To address the three things the commenter cannot discern, the department notes the following:

The department has not broadened the definition of "exclusive provider network." Insurance Code §1301.056 addresses insurer contracts with organizations that have networks of contracted physicians and other practitioners, and Insurance Code §1301.061 addresses insurer contracts with preferred provider organizations. The definition of "exclusive provider network" contemplates applicability of these statutes. In addition, the definition does not lessen an insurer's network adequacy requirement. The sufficiency of a network does not hinge on whether an insurer has directly contracted with each provider in the network or whether the insurer has contracted with an organization that has taken on the task of directly contracting with providers. Instead, it depends on making providers reasonably accessible to insureds.

The benefit that consumers can obtain from an insurer that has contracted with an organization contracted with a network of providers is access to a broader array of providers than otherwise would be available. If the provider is identified as a preferred provider, then the insured will be protected against balance billing. Even if the provider is not identified as a preferred provider, the insured will still benefit by only having to pay the coinsurance amount of a reduced charge with a preferred provider benefit plan, or a discounted amount with an exclusive provider benefit plan.

By addressing both direct and indirect contracts, the department contemplates that insurers are aware of and will follow Insurance Code §1301.056 when assembling their networks.

The department does not agree that the definition of "exclusive provider network" opens the door for insurers to enter into remote or tenuous contracts for purpose of meeting network adequacy requirements.

First, the section is under, and must be read in conjunction with, the law. Insurers must follow Insurance Code §1301.056 and §1301.061 in their dealings with providers and with preferred provider organizations. A creative reading of a definition in a rule would not excuse that statutory requirement.

Second, under the adopted rules the department will review an insurer's network for consistency with the network adequacy requirements adopted in §3.3704. Review will occur on a case-by-case basis, but if an insurer's network is composed of remote and tenuous connections with providers, it will likely not be found adequate.

The department does not agree that exclusive provider benefit plans should be prohibited from using networks that include providers indirectly contracted with under Insurance Code §1301.061. These networks will not lead to consumer confusion or harm. Section 3.3705(b) requires insurers to provide provider listings to insureds, and §3.3705(k) protects insureds from harm if they rely on these listings.

The department does not anticipate applying these rules to exercise direct oversight of contracts insurers enter into with providers or preferred provider organizations under Insurance Code §1301.061. When the department reviews insurers' networks for adequacy, it will rely on the information available to it. The department's duty to review network adequacy does not create a role for the department to act as a referee for contracting between insurers and preferred provider organizations or providers, except to the extent necessary to ensure that insurers comply with applicable statutes and regulations.

The definition of "exclusive provider network" does not conflict with the definition of "preferred provider." The definition for "preferred provider" does not specifically address either direct or indirect contracts, and the relationship between an insurer and a preferred provider could arise through either type of contract. The department does not agree that the definition of "exclusive provider network" could create a regulatory loophole in which insurers could show compliance with network adequacy standards, yet not disclose all contracted providers to insureds. In reviewing network adequacy, the department will look at the network of providers the insurer relies on to meet network adequacy requirements. If no providers are listed, the network would likely not be found adequate. It is also not clear why an insurer would want to hide contracted providers from insureds. If insureds are forced to go out of network because no providers are identified in the provider listings, the costs to the insurer are likely to be higher, especially under the payment requirements of the adopted rule.

In regard to the questions the commenter raises about the loophole the commenter perceives, the department makes the following replies:

1) If an insurer does not list indirectly contracted providers in the insurer's provider listings, then the department would not consider those providers a part of that network. The department would determine the adequacy of the network based on the providers the insurer identifies as a part of the network, and it is these listed providers that a consumer would choose from.

2) An insurer could not satisfy network adequacy with a network lacking in transparency. If the insurer refuses to identify the providers that make up the network, the department would not find the network adequate.

3) A preferred provider can determine whether another provider is a preferred provider by viewing the network's directory. Regardless of how the insurer and provider choose to contract, if the provider is a preferred provider, the provider should be listed in the network's directory.

4) The department will not review every indirect contract between an insurer and the providers that make up the insurer's network through an indirect contract. The department accepts information it receives from an insurer at face value. If the department learns or determines that an insurer has provided false information to support the adequacy of a network, the department will take all appropriate action under department regulations and the Insurance Code.

5) The department will not regulate insurers differently based on how they form their networks. All insurers must comply with the Insurance Code and the department's regulations, regardless of

whether they contract directly with providers or form networks based on contracts with preferred provider organizations.

6) The department does not determine the value of a preferred provider benefit plan. It determines the adequacy of the network the insurer uses for the preferred provider benefit plan and oversees the compliance of the insurer under the Insurance Code and department regulations.

In regard to the commenter's concerns about leasing of providers' rates, the department notes that it does not base its review of network adequacy on the contracts an insurer has, it bases the review on the network the insurer provides. If an insufficient number of providers are included in the network, the department will likely find the network inadequate. So it will not be necessary, as an initial matter, for the department to review an insurer's contracts with those who lease providers' rates, substantiate the existence of the contracts, or otherwise apply the requirements of these rules to the contracts or the entities that lease providers' rates.

The department declines to adopt the proposed section establishing a registration process for preferred provider organizations. The proposed section would constitute a substantive change necessitating re-proposal of these rules. The proposed section also goes beyond the applicability of these rules, as the department does not intend to apply them to regulate preferred provider organizations. Finally, the proposed section is potentially inconsistent with law, as it attempts to interpret applicability of Government Code Chapter 552 to a broad category of information.

Comment: A commenter asks that the department revise the definition of "pediatric practitioner" to reference advance practice nurses in addition to physicians. In support of this recommendation, the commenter notes that advanced practice nurses are referenced in §1301.052 and included in the definition of "practitioner" in Insurance Code §1451.001.

Agency response: The department agrees with the comment, but declines to make the specific change requested. Instead, the department makes a similar change to the change the commenter requests.

The definition "pediatric practitioner" only appears in §3.3707, in regard to waivers from network adequacy requirements. The provisions within the rule that relate to network requirements do not generally address specific provider types, but rather address "physicians or providers." For consistency with that usage, the department has revised the definition of "pediatric practitioner" to be "[a] physician or provider with appropriate education, training, and experience whose practice is limited to providing medical and health care services to children and young adults."

Section 3.3703

Comment: A commenter asks that the department clarify that §3.3703(a)(20) applies to preferred providers and that the obligation to provide detailed reimbursement information under this provision does not equate to claim-specific information.

Agency response: The department disagrees with the comment and declines to provide the requested clarification.

Section 3.3703(a)(20) clearly applies only to contracted providers, so no clarification is necessary.

Regarding application of the section to claim-specific information, the rule requires sufficient information to be provided to allow a provider to determine the amount of payment that will be made for services to be rendered. In most cases this will not require the provision of claim-specific information, but the department declines to state that this will never be the case.

Section 3.3703(a)(23) and (a)(24)

Comment: A commenter observes that the department proposed no revision to §3.3703(a)(23). The commenter asks that the department amend this provision to expressly allow a contract between an insurer and provider to require disclosure of financial interests, rather than just ownership interests, when the provider makes a referral.

The commenter requests that the text be revised to say the following:

(23) A contract between an insurer and a preferred provider other than an institutional provider may contain provisions requiring a referring physician or provider, or a designee;

(A) to disclose to the insured, if applicable:

(i) that the physician, provider, or facility to which the insured is being referred is not a preferred provider; and

(ii) that the referring physician or provider has a financial interest in the physician, provider, or facility to which the insured is being referred.

(B) to disclose to the insurer, if applicable:

(i) on an annual basis the financial interests the preferred provider has in other physicians and health care providers. The contract also may contain provisions requiring disclosure of changes that have occurred from a previous disclosure. Such additional disclosures should be reasonable in time and allow at least 60 days notice after a material change in the financial interests of a preferred provider.

(C) For purposes of paragraph (23) of this subsection, the term "financial interests" may be defined by the contract provided that the definition requested by an insurer is reasonably consistent with the definition of "financial interests" in §180.24(a)(2) of this title or analogous federal regulations defining what constitutes the "financial interests" of health care providers in other health care providers.

Agency response: The department disagrees with the comment and declines to make the proposed change. The change requested by the commenter would address a new notice requirement that might be required by contract and would create a new definition for use in the provision. The department believes this would constitute a substantive change necessitating a new rule proposal.

The department notes that the provision is optional and insurers and providers are entitled to enter into contractual arrangements that are not otherwise prohibited by law, so an insurer could negotiate a contract provision as contemplated by the commenter without it being referenced in rule.

Comment: A commenter opposes modifications to §3.3703(a)(23) suggested by a commenter during the public hearing on the proposed rules. The commenter's opposition to the suggested modifications is based on the commenter's continued opposition to the use of out-of-network referral and ownership interest forms.

The commenter discusses the history of these forms and the instances when the commenter has seen insurers require these forms. The commenter says these forms discourage a physi-

cian from discussing and recommending treatment options and services that are out-of-network. The commenter is concerned that if the department incorporates the suggested revisions into the rule, insurers will use them as a pretext to intimidate and terminate network physicians. The commenter says insurers have already brought lawsuits against doctors and surgery centers owned by doctors in several states based on this issue.

As an alternative to the modifications to §3.3703(a)(23) and (a)(24) suggested by a commenter during the public hearing on the proposed rules, the commenter suggests the department adopt a new section prohibiting insurers from requiring that providers disclose ownership interests in facilities to which they refer insureds. The commenter provides the following text for this section:

Section 3.37XX. Interference in recommended treatment prohibited. (a) An insurer may not require, through contract or otherwise, a preferred provider to complete or retain a document substantiating the disclosure of financial or ownership interests or the insured's acknowledgment of such disclosure.

(b) An insurer may not require, through contract or otherwise, a preferred provider to recommend treatment to be provided by alternate preferred provider.

(c) Pursuant to Insurance Code §1301.151, an insurer may not require, directly or indirectly, through contract or otherwise, an insured to sign or otherwise execute a document acknowledging financial or ownership disclosures or consenting to referrals to certain physicians or health care providers. As used in this subsection, "acknowledging financial or ownership disclosures" includes affirmations that the insured understands and acknowledges the limitations of the benefits provided when receiving care from nonpreferred providers.

Agency response: The department agrees in part and disagrees in part with the comment and has made a change to the rule text. The department declines to adopt the new section suggested by this commenter. However, the department adopts minor clarifying amendments to §3.3703(a)(23).

The department amends the text as adopted to provide that in a contract provision under §3.3703(a)(23) a referring physician or provider needs to disclose that the physician, provider, or facility to which the insured is being referred might not be a preferred provider.

The department also revises the text to clarify that the requirement that a referring physician or provider disclose an ownership interest is only applicable if the physician or provider actually has an ownership interest in the provider that the insured is being referred to.

In providing this clarification, the department notes that the rule provision is optional and subject to the agreement of the insurer and the preferred provider.

The department declines to adopt the suggested new section because it would impose new requirements on insurers not addressed in the rule proposal. This would constitute a substantive change necessitating a new proposal before adoption. Further, in the absence of clear statutory guidance on the issue, it is the department's position that insurers and providers are free to agree to any contractual arrangements and requirements that are not prohibited by statute or regulation.

Section 3.3703(a)(27) and Figure 3.3705(f)(1)

Comment: A commenter observes that the notification requirements of §3.3703(a)(27) and the figure in §3.3705(f)(1) do not include exceptions for emergency providers. The commenter assumes the department intended to include an exception, because it is not feasible for an emergency care provider to provide advanced notices or estimates. Without clarification one might read these provisions as applicable to emergency care providers. The commenter asks the department to add the words "except in cases of emergency care" to the provisions.

A second commenter also requests clarification of §3.3703(a)(27) and Figure: 28 TAC §3.3705(f)(1). The commenter asks that the department add exceptions for emergency care services to prevent confusion and avoid delays for patients in emergency care situations. A third commenter raises this point in regard to both §3.3703(27) and §3.3703(28).

Agency response: The department agrees that notice requirements are not applicable in cases of emergency and has adopted revised text to clarify this.

The department has used the first commenter's requested change for §3.3703(a)(27) in part, but has also included a reference to Insurance Code §1301.155. The department adopts an equivalent change in §3.3703(a)(28).

In regard to the figure in §3.3705(f)(1), the department declines to add a specific reference to emergency services. Instead, the department revises the text to note that an insured has "the right, in most cases, to obtain estimates in advance from out-of-network providers of what they will charge for their services; and from your insurer of what it will pay for the services."

This amendment will address emergency situations, but it will also address other situations where an insured may not able to obtain advance estimates of out-of-network provider charges or insurer payment.

Section 3.3703(a)(27) and (28)

Comment: A commenter asks that the department not adopt proposed §3.3703(a)(27) and (28). The commenter disagrees with the policy that insurers should have the opportunity to coordinate an insured's care. The commenter suspects the provisions were proposed so that insurers would have notice and time to coax patients into a facility the insurer prefers and says the provisions are contrary to a patient's freedom of choice and infringe on the professional judgment of physicians.

The commenter says that the notices required under §3.3703(a)(27) and (28) are broader than disclosures under other laws and that the department would be over reaching if it adopted them. The commenter says the provisions reflect a department philosophy to deflect insurer responsibility and put burdens on patients and physicians.

A second commenter says that §3.3703(a)(27) and (28) are awkwardly worded and appear to create a duty that an insurer coordinate an insured's care. A third commenter also raises this point, saying that proposed §3.3703(a)(27) and (28) may create new duties that may or may not exist in a policy and are not derived from specific statutes, because insurers marketing preferred provider benefit plans are not required to coordinate an insured's care.

The second commenter says that while some insurers are involved in coordination of care in some complex cases, not every insurance policy requires coordination of care and not every case needs coordination. The commenter says that the amendments

to §3.3703(a)(27) and (28) may not be necessary, because a large number of insurance contracts require pre-authorization for surgical procedures.

A fourth commenter generally supports the addition of §3.3703(a)(27) and (28) and says they will help consumers be more aware of the possibility of balance billing and help them avoid it. The commenter understands what is meant by the word "coordinate," but recommends changing the language to more accurately reflect that it refers to the ability of the insured to contact the insurer for any help the insurer can provide in preventing an unexpected balance bill, such as giving information on expected out-of-pocket costs and the availability of network providers.

A fifth commenter says that proposed §3.3703(a)(27) and (28) unnecessarily increase administrative costs by mandating re-contracting. The commenter says that because the department can only address a provider's disclosure through the provider contract, the department has no authority to enforce the providers' obligations to consumers.

Agency response: The department disagrees with the first, second, fourth, and fifth commenters, but makes a clarifying change. The department agrees with the third commenter, and uses the third commenter's suggestion in clarifying the provisions.

In regard to the first commenter, the department notes that it was not the department's intent to imply that an insurer could limit an insured's choice of provider or interfere with medical care. Nor, in regard to the issue raised by the second commenter, did the department intend to create a duty for insurers to coordinate care in instances where it does not otherwise exist.

To address these concerns, the department has deleted the phrase "to coordinate the insured's care" from §3.3703(a)(27)(A) and §3.3703(a)(28)(A) and replaced it with the phrase "for more information."

The department has also deleted the phrase "so that the insurer has the opportunity to coordinate the insured's care" from §3.3703(a)(27)(B) and §3.3703(a)(28)(B).

In light of complaints the department has received regarding balance billing, the department believes it imperative that both insureds and insurers have more opportunities to know in advance what potential costs may arise from a surgery to reduce the likelihood of being surprised by a balance bill.

The department declines to make a change in regard to the issue raised by the third commenter. The department notes that a number of other new requirements are imposed on provider contracts through the rule, reducing the cost of this particular requirement.

As discussed in the rule proposal preamble, the department has considered the cost of this requirement against the benefits to consumers. This requirement is necessary to provide consumers the opportunity to obtain in-network care and to give an insurer the opportunity to prevent insureds from being surprised by balance billing by out-of-network providers, especially at in-network facilities.

Insurers offering preferred provider benefit plans have an obligation under Insurance Code §1301.005 to ensure that preferred provider benefits are reasonably available to all insureds. The adopted subsections insure that insureds have the opportunity to obtain care from in-network providers when possible.

The required notice to the insurer regarding surgery is necessary to permit the insurer to comply with the requirement of Insurance Code §1301.005 that the insurer reimburse out-of-network physicians at the in-network coinsurance percentage when contracted physicians are not available. It is also necessary to enable an insurer to comply with the requirements of §§1301.005, 1301.0055, and 1301.006, to make contracted providers reasonably available and accessible to all insureds.

Regarding authority to enforce provider obligations to consumers, the department notes that §3.3703 contains multiple requirements for contracts between insurers and providers. The department has authority to review insurers' contracts with providers to confirm that provisions required by statute or rule are included.

The department does not regulate a provider who enters into a contract with an insurer. However, if a provider violates the terms of a contract with an insurer, the provider is subject to termination of the contract. The department is able to take action against an insurer that does not enforce the contractual provisions required by the rule.

Comment: A commenter recommends strengthening the notice provided from a facility to an insured under §3.3703(a)(28)(A) by also requiring that contracts direct facilities to notify insureds of the contact information for the specific person or office within the facility who can provide information on expected charges and potentially help schedule care so that it is performed by network providers.

Agency response: The department disagrees with the comment and declines to make the requested change.

The department must balance the administrative costs of requiring facilities, entities not directly regulated by the department, to continually update specific contact information against the additional benefit to the consumer. The department believes that consumers already have sufficient access to facility billing and scheduling personnel so as to render provision of specific individual contact information unnecessary.

Section 3.3703(a)(29)

Comment: A commenter opposes proposed §3.3703(a)(29). The commenter says that the provision would impair the department's authority to regulate the marketplace conduct of insurers and undercut the department's regulatory enforcement authority. The commenter says the section would so hinder the department's enforcement of contract prohibitions that it would eviscerate patient rights under Insurance Code Subchapter D, Chapter 1301.

Agency response: The department agrees in part and disagrees in part.

The department does not agree with the commenter's reason for deleting the provision, because the department is generally only authorized to prohibit actions which are prohibited by statute or regulation. It is also the department's position that insurers and providers are entitled to negotiate for any contractual provisions they choose, unless prohibited by law.

The department agrees that the language is unnecessary in order for the department to regulate insurers and carry out the department's statutory responsibilities. Accordingly, the department withdraws proposed §3.3703(a)(29).

Comment: A commenter supports proposed §3.3703(a)(29).

Agency response: The department appreciates the supportive comment but, based on other comments, has declined to adopt §3.3703(a)(29).

Section 3.3704(a)(1) and (11)

Comment: A commenter opposes the exception for exclusive provider benefit plans addressed in §3.3704(a)(1) and asks that the department strike it in its entirety.

The commenter says that the provision would allow exclusive provider benefit plans to require insureds to have services performed by particular hospitals, physicians, or practitioners. The provision would prevent the department from finding an insurer unjust or in violation of the Insurance Code, even if the insurer's exclusive provider benefit plan only has one hospital or one physician of a certain specialty.

The commenter says that, coupled with other provisions in the rule concerning mediation, §3.3704(a)(1) would let an insurer force an insured to participate in mediation for emergency services any time the one hospital in the insurer's network was on diversion status. The commenter adds that even in nonpreferred provider situations an insurer cannot dictate a particular hospital, physician, or practitioner under the proposed rules and says that this shows §3.3704(a)(1) is unnecessary and unsupported.

The commenter also addresses §3.3704(a)(11), saying it appears the department proposed the amendment to §3.3704(a)(11) to reflect the closed nature of exclusive provider benefit plans. However, the commenter says the proposed amendment is overly broad and one could read it as exempting exclusive provider benefit plans from having to make preferred provider benefits reasonably available to insureds within a designated service area.

As an alternative to the proposed amendment, the commenter suggests the department adopt a new §3.3704(b) that reads as follows:

(b) Notwithstanding subsection (a)(11) of this section, an exclusive provider benefit plan is not considered unjust under Insurance Code §§1701.002 - 1701.005, 1701.051 - 1701.060, 1701.101 - 1701.103, and 1701.151; or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, or §§544.051 - 544.054, or to violate Insurance Code §§1451.101 - 1451.127, provided that:

(1) the exclusive provider benefit plan complies with subsection (a)(1) - (10) and (12) of this section, and;

(2) for the purposes of subsection (a)(11) of this section, an exclusive provider benefit plan must only ensure that preferred provider benefits are reasonably available to all insureds within a designated service area.

Agency response: The department agrees in part and disagrees in part with the comment. The department has made the suggested changes.

In regard to the comment concerning §3.3704(a)(1), the department agrees that an exclusive provider plan is not permitted to require that a service be rendered by a particular physician or provider. However, the department does not agree that the proposed language would permit insurers to require that insureds receive services from particular providers. The department agrees to withdraw the proposed additional new text for 3.3704(a)(1) to avoid confusion on this point.

The department notes that it could approve an exclusive provider benefit plan that contains limited numbers of providers, so long as the network meets the network adequacy requirements contained in §3.3704.

The department agrees with the commenter regarding §3.3704(a)(11) and agrees to make the change the commenter suggests. The department has redesignated the remaining subsections as appropriate to reflect addition of this new subsection (b).

Section 3.3704(a)(12)

Comment: A commenter recommends the department revise §3.3704(a)(12) by adding the word "reasonably" as follows: "if medically necessary covered services are not reasonably available through preferred physicians or providers..."

Agency response: The department agrees with the comment and has adopted the requested change.

Section 3.3705(b)

Comment: A commenter appreciates the department's decision to not propose an amendment to add the words "as applicable" to §3.3705(b). The department had included this proposed amendment in the withdrawn June 29, 2012, rule proposal.

Agency response: The department appreciates the supportive comment.

Section 3.3705(b)(1)

Comment: A commenter recommends that the department modify the proposed language for §3.3705(b)(1) to ensure that the subsection requires an insurer to provide to consumers in its written description adequate information regarding their exclusive provider benefit plan coverage. The commenter suggests the department revise the paragraph to include the words "and written description and/or required by law" as follows:

"(1) A statement that the entity providing the coverage is an insurance company; the name of the insurance company; that, in the case of a preferred provider benefit plan, the insurance contract contains preferred provider benefits; and, in the case of an exclusive provider benefit plan, that the contract only provides benefits for services from preferred providers, except as otherwise noted in the contract and written description and/or required by law..."

Agency response: The department agrees it is important to provide consumers accurate information about their coverage. The department also agrees with the general content of the recommended language.

The department has modified the suggested language to provide additional clarification by replacing the words "and/or" with "or as otherwise."

Section 3.3705(b)(14)

Comment: A commenter notes that the department proposes to delete §3.3705(b)(14), which requires insurers to disclose network demographic information to current or prospective insureds and group contract holders in the written description of the terms and conditions of the policy.

The commenter references portions of the May 19, 2011, adoption order preamble where the department states reasons for adoption of §3.3705(b)(14).

The commenter says that there is a clear need for insurers to disclose network demographic information. The best way to prevent unanticipated balance billing is for the department to require that health plans inform consumers regarding the composition of their networks. This will enable consumers to assess the potential for balance billing and to choose, as they see fit, plans that offer more robust networks.

The commenter does not think §3.3705(b)(14) will result in increased premiums because compliance should be limited to minimal printing costs, which insurers could easily absorb. The benefits to consumers, in the form of more complete networks, more predictable out-of-pocket expenses, increased network transparency, and more informed decision making, clearly outweigh any negligible increases in expense to insurers. The commenter also contests arguments that the requirements of §3.3705(b)(14) could result in consumers getting misleading information.

The commenter points out that the provision's requirement for an annual update of information is a minimum standard and that insurers will be motivated to provide it more often for competitive advantages and marketing purposes. The commenter says that only insurers with weak networks would want to avoid disclosing network information. The commenter also notes that insurers are required to provide a notice to insureds of substantial decreases in network strength under §3.7505(n). The commenter also points out that under §3.3705(q) as adopted May 19, 2011, a plan designated as an "Approved Hospital Care Network" loses this status and must provide notice to the department and insureds if it becomes noncompliant with the network adequacy requirements for hospitals and fails to correct this within 30 days.

The commenter says that the department's proposed amendments to §3.3705(b)(14) to insert reporting requirements related to an insurer's waivers and local market access plans are not a sufficient replacement for the provisions being removed.

The commenter summarizes the comment by saying that the department's proposed revision of §3.3705(b)(14) fails to promote plan transparency regarding the adequacy of networks, enable informed consumer decision-making, incentivize plans to contract with an adequate network of physicians and to hold plans publically accountable for their network composition, align with the department's own previous position on this issue, or conform to the department's charge under HB 2256.

The commenter urges the department to retain the language adopted May 19, 2011, and reject the proposed new language.

Agency response: The department agrees that the language in proposed §3.3705(b)(14) should be retained. As adopted, the department removes the proposed amendments to §3.3705(b)(14) and withdraws the proposed text deletions. The department has placed the new text it had proposed for §3.3705(b)(14) into a new §3.3705(b)(15).

Section 3.3705(f)(1) and (f)(2)

Comment: A commenter says that the proposed rule appears to change the notice required under the figure in §3.3705(f)(1). The commenter says that instead of notifying insureds that payment of claims for out-of-network providers will be at the "network coinsurance rate," the proposed change deletes the word "coinsurance" and adds the word "deductible."

The commenter says this amendment may be confusing if the department does not change the additional requirements relating to payment using a "usual and customary" standard. The commenter says one could tie the reference to "rate" to a usual and customary rate as opposed to the different levels of coinsurance.

The commenter says the provision also seems contrary to language in Insurance Code Chapter 1305 regulating preferred provider benefit plan contracts. Specifically, Insurance Code §1301.0046 refers to "coinsurance" differences, not rates, and Insurance Code §1301.005(b) requires reimbursement of out-of-network services at the same "percentage level of reimbursement."

The commenter says the differences in most contracts involving preferred provider services and nonpreferred provider services is expressed as a percentage difference or "coinsurance" and are not necessarily expressed as a rate.

The commenter suggests that the department not adopt the figure.

A second commenter also addresses the figure in §3.3705(f)(1), as well as the figure in §3.3705(f)(2). The commenter suggests revising the sentence following the second bullet under the words "You have the right to an adequate network of preferred providers (also known as 'network providers')" in the figure in §3.3705(f)(1) and the last sentence of the last bullet in the figure in §3.3705(f)(2) to say "If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits."

Agency response: The department agrees in part and disagrees in part.

The department agrees that the language as proposed could be construed as ambiguous, but prefers to revise the figure, rather than not adopt it as requested by the first commenter, since it provides important information to insureds.

To clarify the possible ambiguity in the figure in §3.3705(f)(1), the department has revised the language to more closely track the statute. The department used part of the second commenter's suggested text to do this, revising the third sentence of the notice to state, "If you relied on materially inaccurate directory information you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement..."

The department has incorporated the second commenter's suggested change into the figure in §3.3705(f)(2).

Section 3.3705(f)(2)

Comment: A commenter says the proposed figure in §3.3705(f)(2) seems to suggest that if an insurer approves a nonpreferred provider, the insurer must resolve the nonpreferred provider's bill so that an insured only has to pay applicable coinsurance, co-pay, and deductibles. The commenter says this duty does not exist in statute and conflicts with statutory provisions that discuss what must be done.

First, the commenter says, Insurance Code §1301.005(b) does not require an insurer to resolve a nonpreferred provider's bill. Instead, it only requires an insurer to use certain reimbursement levels. An insurer does not have a contract with a nonpreferred provider and has no legal right to require that a nonpreferred provider charge a specific rate.

The commenter says an insured may have a right to reimbursement and may assign that right to a provider to collect benefits, but the issue of whether an insured may have to pay additional amounts is not within the control of the insurer.

Second, the commenter says the notice conflicts with Insurance Code §1301.0053. This section requires than an insurer reimburse emergency care at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider. The proposed notice confuses these two standards and suggests that the standard for emergency care may also apply to other non-emergency care situations.

The commenter says the figure ignores the fact that an insurer contracts with preferred providers, but not nonpreferred providers. A nonpreferred provider could bill a patient the difference between the reimbursement and whatever "full charge" the nonpreferred provider charges, and the insurer has no control on what the nonpreferred provider will agree to charge or accept.

Agency response: The department disagrees with the comment and declines to make a change.

Prior to the bill's passage, the 82nd Legislature amended the text of HB 1772 during the legislative session to include language regarding insurer payment of claims when no preferred provider was available, and provided for payment of claims in cases of emergency that tracks the health maintenance organization statutory language. At the time HB 1772 passed, the legislature was aware that the department has construed the health maintenance organization language to require health maintenance organizations to hold enrollees harmless in these situations. See *Biennial Report of the Texas Department of Insurance to the 80th Texas Legislature* at pages 10-12, tdi.texas.gov/reports/documents/finalbie07.pdf.

As the House Research Organization's report on HB 1772 (82nd Legislature, 2011) notes, the bill was amended to require that insurers offering preferred provider benefit plans "fully reimburse" out-of-network providers in both of these situations. See *House Research Organization Bill Analysis for HB 1772* which can be found on the House Research Organization's website at hro.house.state.tx.us/pdf/ba82r/hb1772.pdf#navpanes=0.

The consumer notice in §3.3705(f)(2) accurately reflects the requirement of the rule, informing consumers that insurers have additional payment responsibilities in circumstances of inadequate networks or emergencies.

Comment: A commenter says that insurers would like the option to offer products that continue to provide coverage for some, but not all, out-of-network services. The commenter uses transplants as an example, saying that this could be a service conducive to a closed network benefit, limited to recognized centers of excellence, while other services are available from both in and out-of-network providers.

The commenter says that HB 1772 allows for this interpretation of the term exclusive provider benefit plan, in that it says an "exclusive provider benefit plan" is a benefit plan in which an insurer excludes benefits to an insured for "some or all services" provided by a physician or health care provider who is not a preferred provider.

The commenter recommends the department revise the first bullet of the notice required by §3.3705(f)(2) to include optional text an insurer can choose from to describe the format of the insurer's exclusive provider benefit plan.

The commenter suggests the following text:

An exclusive provider benefit plan described in your policy:

[Option 1] provides no benefits for services you receive from out-of-network physicians and providers other than emergency care services.

[Option 2] provides no benefits for one or more specific types of services you receive from out-of-network physicians and providers, other than emergency care services.

[Option 3] provides no benefits for services you receive from one or more physicians and providers, other than emergency care services.

[Option 4] other than emergency care services it provides:

- no benefits for one or more specific types of services you receive from out-of-network physicians and providers, and,

- no benefits for services you receive from one or more specific physicians and providers.

Agency response: The department disagrees and declines to make a change.

The department's review of Insurance Code Chapter 1301 does not reveal an intent by the legislature to permit hybrid preferred and exclusive provider benefit plans or any indication of how such plans would be regulated. To the contrary, Insurance Code §1301.0045(b) specifically states that, except for two limited exceptions, the chapter "may not be construed to require an exclusive provider benefit plan to compensate a nonpreferred provider for services provided to an insured." If hybrid plans were intended, the legislature would not have both broadly and specifically granted them exemption from many preferred provider plan requirements in the chapter relating to out-of-network services and payments.

Insurance Code §1301.0046 imposes a maximum coinsurance applicable to the payment of nonpreferred providers to 50 percent of the total covered amount, but exempts exclusive provider benefit plans from this requirement. If hybrid exclusive provider plans with out-of-network benefits were intended to be permitted, the legislature would not have granted exclusive provider benefit plans a blanket exemption from this requirement. Similarly, Insurance Code §1301.005 requires preferred provider plans to make out-of-network benefits reasonably available, but the legislature granted exclusive provider plans a blanket exemption from this requirement.

Permitting hybrid plans would allow an insurer with a single exclusive provider benefit plan element to claim an exemption from paying out-of-network providers at least 50 percent of the covered amount and from having to make out-of-network benefits reasonably available for all the other preferred provider plan elements of the product. Also, in Insurance Code §1301.1581, the legislature required that exclusive provider benefit plans note that they are such on their identification cards, again with no reference of what should be required in the case of a hybrid plan. Given that such hybrid plans could have few or many out-of-network benefits, such a blanket requirement could be misleading to providers and insureds.

Finally, in Insurance Code §1301.0052 and §1301.0053 the legislature specified payment protections for insureds under exclusive provider benefit plans in certain circumstances separate from the requirements imposed on preferred provider benefit plans but did not specify what requirements would apply in those circumstances in the context of a hybrid product. Viewed as a whole, it is clear that the legislature did not contemplate imposing any requirements of the chapter on hybrid plans.

As the sole basis for the construction that the definition of "exclusive provider benefit plan," the commenter asserts that Insurance Code §1301.001(1) references a "plan in which an insurer excludes benefits to an insured for some or all services, other than emergency care services required under §1301.155, provided by a physician or health care provider who is not a preferred provider" and that the reference to the possibility of excluding coverage of "some" rather than all out of network services indicates an intent to permit hybrid plans. The department notes that the definition in the final enrolled bill was unchanged from the initial filing of the bill. From the initial filing of the bill, the definition referenced out of network emergency services. During the legislative development of the statutes, the legislature added §§1301.0052 and 1301.0053 to specify out of network payment requirements for both emergency and inadequate network situations.

The department's position is that the reference to "some" out of network services referenced inadequate network situations in which exclusive provider benefit plans, like health maintenance organizations, would be required to cover services when there are no network providers available.

Because hybrid plans would require harmonizing the preferred and exclusive provider benefit plan regulations in regard to a single product, substantial additions to the current rule would be required. Because stakeholders have not been put on sufficient notice to permit comments on the advisability of hybrid plans or the regulations that should apply to them, the department does not believe it is appropriate to insert such regulations at this time.

Finally, the department believes that there are sufficient public policy reasons to reject hybrid products pursuant to its rulemaking authority under Insurance Code Chapter 1701 and that authorization should be left until sufficient regulations can be developed or the legislature addresses the issue. Given that hybrid products could contain a single preferred provider element or a single exclusive provider element only, or they could contain mixes of the elements in confusing ways, the department believes that such products would be sufficiently confusing to consumers to be unjust, encourage misrepresentation, or be deceptive under Insurance Code §1701.055 and the commissioner's other rulemaking authorities. The department is concerned, for instance, that an insurer could pick and choose which services to make exclusive or preferred depending on the types of providers that the insurer could negotiate favorable contracts with or depending on which provider types would result in lower claims costs for the insurer. Insureds could be required to consult their plan documents for each service to determine whether it was an exclusive or preferred provider benefit.

Section 3.3705(l)(2) and (3)

Comment: A commenter opposes the department's proposed deletion of §3.3705(l)(2) and (3).

The commenter notes that §3.3705(l)(2) requires an insurer to include in its provider listing information regarding a method for insureds to identify, for each preferred provider hospital, the percentage of the total dollar amount of claims filed with the insurer by or on behalf of facility-based physicians that are not under contract with the insurer. The insurer must make this information available by class of facility-based physician, including radiologists, anesthesiologists, pathologists, emergency department physicians, and neonatologists.

The commenter says that §3.3705(l)(3) provides insurers with direction for implementing §3.3705(l)(2) by specifying the claims that an insurer should consider in determining the percentages under §3.3705(l)(2).

The commenter supports its opposition to the department's proposed deletion of §3.3705(l)(2) and (3) by referencing statements the department made in support of adoption of the provisions in its May 19, 2011, adoption order. The commenter says that the department's proposed deletion of §3.3705(l)(2) and (3) undermines the collective impact of the transparency provisions of §3.3705(l).

The commenter concludes by urging the department to not adopt its proposed deletion of §3.3705(l)(2) and (3).

Agency response: The department agrees with the comment and withdraws its proposed deletion of §3.3705(l)(2) and (3). As proposed, §3.3705(l) only referenced "the requirements in paragraphs (1) - (7)." For consistency with the withdrawn deletion of §3.3705(l)(2) and (3), the department revises §3.3705(l) to reference "the requirements in paragraphs (1) - (9)."

Section 3.3705(m)

Comment: A commenter supports the annual policyholder notice required by §3.3705(m), but recommends that the notice be improved to give consumers access to all relevant information on the waiver and local market access plan in one place.

The commenter says that, in addition to providing a link to the online listing of regions, counties, or ZIP codes where the network is inadequate, the notice should point consumers to two other important pieces of information: (1) how they can obtain or view the full local market access plan, and (2) a link to the department's web page on waivers that have been granted.

The commenter suggests revising §3.3705(m) to include paragraphs that list the items an insurer must include in the annual policyholder's notice and suggests adding "information on how the local market access plan may be obtained or viewed" as paragraph (2) and "a link to the department's website with information relevant to the grant of waivers established under §3.3707(f)" as paragraph (3).

The commenter suggests including in §3.3705(m) a link to the department's website that lists information relevant to waivers under §3.3707(f).

The commenter also says the notice required by §3.3705(m) should identify how one may obtain an insurer's local market access plan. The commenter says that while the notice as proposed provides a link to a listing of geographic areas where a network is inadequate, the local market access plan would provide additional valuable information to consumers. The commenter observes that insureds will get information on how to view the local market access plan in the policy terms and conditions under §3.3705(b)(14)(C), but says that including the information in the annual notice that is specific to the access plan will help insureds get all of the relevant information on the access plan in one place.

Agency response: The department agrees with the comment in part and disagrees in part. The department has made a revision to the adopted rule text in response to the comment.

Adopted §3.3705(b)(15) requires that insurers include in its consumer disclosure information regarding whether a waiver or access plan applies to the insurer's product and how the access plan may be obtained or viewed. The rule already incorporates the commenter's suggestion to some extent.

However, the department agrees that, just as consumers may want information about the access plan utilized by an insurer, they may also want information on waivers from network adequacy requirements the department has granted the insurer. The department has adopted an amendment to require that insurers include in their annual notice information on how an insured can obtain or view any local market access plans the insurers use and a link to the department's website that relates to the grant of waivers under §3.3707(f). The department's web address for this information currently is: tdi.texas.gov/wc/wcnet/documents/RuleEPOWaiverRe.docx.

The department declines to include a specific web address within the rule text, because any future change to the website address would necessitate an amendment to the rule.

In addition, the amendment requires that insurers provide in their annual policyholder notice a link to the department's website that lists information relevant to waivers established under §3.3707(f). This information will be more accessible to insureds than the rule text, and it will suffice to provide notice of where insureds can obtain information regarding the insurer's waivers.

Section 3.3705(n)

Comment: A commenter opposes the department's proposed deletion of the text in §3.3705(n) adopted May 19, 2011. The commenter says §3.3705(n) should be retained because it would aid consumers in decision making and reduce incidents of unanticipated balance billing.

The commenter references portions of the May 19, 2011, adoption order preamble where the department states reasons for adoption of §3.3705(n).

The commenter disputes arguments that disclosures under §3.3705(n) might be misleading in instances where decreases in the availability of network providers are temporary due to contract negotiations. There is a low risk of insureds getting misleading information, because the information required under the section is posted in online directories and can easily be updated.

The commenter says that a short-term failure to meet network requirements is no less of a true failure and that even an insurer's temporary non-compliance with network adequacy requirements directly impacts consumer financial responsibilities.

The commenter also points out that §3.3705(n) does not impact short-term contract terminations because it allows for a two-day implementation period. If a contract ceases for only two days or less, an insurer would not need to take action under §3.3705(n). Further, the rule allows an insurer to remove a notice that is posted if adequate providers become available, six months after the insurer posts notice, or the date on which the insurer notifies the department by email that a provider contract termination does not result in non-compliance with adequacy standards.

The commenter says that insureds are not sufficiently protected by the requirement that an insurer provide updated provider listings under §3.3705(i) and (j), and the detrimental reliance provisions under §3.3705(k), to justify deletion of §3.3705(n). The commenter observes that §3.3705 only requires that listings be updated at least every three months, while §3.3705(k) is only a back-end measure and places the burden on an insured to show detrimental reliance on inaccurate listings.

The commenter asks that the department retain the text of §3.3705(n) that the department adopted May 19, 2011.

Agency response: The department agrees to withdraw its proposed deletion of the text in §3.3705(n) that the department adopted May 19, 2011.

Comment: A commenter observes that proposed §3.3705(n), which is adopted as §3.3705(o), requires an insurer to include in all policies, certificates, and outlines of coverage required disclosures regarding reimbursement for out-of-network services. The commenter asks that the department allow insurers the option to provide the notice separately to avoid the administrative costs associated with filing amendments to approved policy and certificate forms.

The commenter also notes that Insurance Code Chapter 1456 contains specific disclosure obligations related solely to facility-based providers, but that §3.3705(n)(3)(D) implies that the obligation to provide an estimate for facility-based provider services applies to all out-of-network providers. The commenter requests clarification.

Finally, the commenter asks that the department recognize the fiscal implication of requiring insurers with preferred provider benefit plans to revise and file all of their contract forms to comply with the new disclosure requirements.

Agency response: The department disagrees with the comment and declines to adopt the change requested by the commenter.

Because the disclosure required by proposed §3.3705(n), adopted §3.3705(o), concerns insurer claims payment under the policy, the department believes that an insurer must incorporate the required disclosures into the policy so that it will clearly be binding on the insurer.

The department notes that the rules require a number of changes to policy forms, but that an insurer may consolidate all changes into a single filing with the department. Insurers may file a unified endorsement containing all necessary new language and then utilize that endorsement with all appropriate products.

The department agrees the rule applies the required estimate to all nonpreferred provider services in cases where the insurer bases its reimbursement of nonpreferred providers on any amount other than full billed charges. If an insurer determines out-of-network reimbursements by applying a percentage stated in the policy to the billed charge, the disclosures would not be required. However, in all other cases, this additional protection for consumers is necessary so that consumers will be able to know, prior to services being rendered, what the insurer will pay for an out-of-network service.

The department would consider failure of an insurer to specify what the policy will pay under these circumstances, without also providing an alternative method of determining what the payment will be in the manner prescribed by the rule, to be unjust under Insurance Code §1701.055. Further, the department would consider a preferred provider benefit plan that does not permit ready access to estimates of what out-of-network providers will be paid to not be making those covered benefits reasonably available under Insurance Code §1301.005(a).

Section 3.3705(p) and (q) and the text that was located in §3.3707(f)

Comment: A commenter opposes the department's proposed deletion of §3.3705(p) and (q), which provide for insurer designation of networks as "approved care hospital care networks" or "limited care hospital care networks," based on whether the

insurer's network met network adequacy requirements for hospitals.

The commenter says insurers may want §3.3705(p) and (q) removed to avoid public accountability regarding plan compliance failures and plan responsibility for unanticipated balance bills. However, the commenter says, removal of these provisions works to the detriment of insureds by depriving them of the ability to investigate their options.

The commenter says that providing an easily understandable designation for insureds promotes transparency and aids in decision-making. The commenter adds that §3.3705(p) and (q) aid meaningful department oversight of an insurer's network adequacy compliance. However, the commenter says, removal of these provisions would permit insurers to move forward with forms that are unjust, deceptive, and encourage misrepresentation.

Finally, the commenter says that insureds are not sufficiently protected by the requirement that an insurer provide updated provider listings under §3.3705(i) and (j), and the detrimental reliance provisions under §3.3705(k), to justify deletion of §3.3705(p) and (q). The commenter observes that §3.3705 only requires that provider listings be updated at least every three months, while §3.3705(k) is only a back-end measure and places the burden on an insured to show detrimental reliance on inaccurate listings.

The commenter asks that the department retain §3.3705(p) and (q).

In conjunction with this request, the commenter asks that the department retain the following text in §3.3707, which the department proposed to delete from §3.3707(f):

An insurer that is granted a waiver under this section concerning network adequacy requirements for hospital-based services is required to comply with §3.3705(p) of this subchapter (relating to Nature of Communications with Insureds, Readability, Mandatory Disclosure Requirements and Plan Designations). The insurer is required to designate such plan as a "Limited Hospital Care Network."

In support of the request, the commenter references portions of the May 19, 2011, adoption order preamble where the department states reasons for adoption of the text.

Agency response: In regard to the proposed deletion of §3.3705(p) and (q) the department agrees in part and disagrees in part with the commenter. The department withdraws the proposed deletion of §3.3705(p) and (q). However, it revises the text of §3.3705(p) as described in this response.

The department agrees that plan designations are important consumer protections, but this information is subject to frequent change, while policy documents are only issued on an annual basis.

On balance, the department has determined that this information is not necessary on the policy or certificates, which are issued after the insurance has been purchased. The information should be maintained on the outline of coverage and the cover page of any provider listing describing the network, which are used much more often by consumers seeking to understand their coverage and are much more easily updated by insurers. The rule text has been amended accordingly.

In regard to the text that the department proposed to delete from §3.3707(f), the department agrees with the comment and withdraws the proposed deletion of the text addressed by the comment. Because of new subsections included in §3.3707, the department has redesignated the subsection that contains the text addressed by the comment.

Section 3.3707

Comment: A commenter offers general support for the provisions addressing waiver of network adequacy requirements, which are adopted in §3.3707. The commenter says these requirements will benefit consumers by helping to ensure that networks are adequate up front.

The commenter says that the additions under §3.3707(b)(1)(A) - (E) are reasonable and appropriate requirements for an insurer seeking a waiver from network adequacy requirements, and they must be adopted to ensure a meaningful review of waiver requests.

The commenter supports the addition of §3.3707(c), which requires an insurer to file its local market access plan at the same time it makes a waiver request. The commenter says that ensuring that insurers have compliant local market access plans that are sufficient to help insureds access care in an inadequate network is an appropriate prerequisite for marketing a plan under a waiver. The commenter also supports §3.3707(g)(2) and (i), which require an insurer to submit a local market access plan at the same time it submits a waiver request at renewal or the network falls out of compliance with network adequacy standards.

The commenter also supports §3.3707(j) and (k), which outline minimum standards for local market access plans and related procedures. The commenter believes these provisions should be maintained to protect consumers.

Agency response: The department appreciates the supportive comment.

Comment: A commenter says that §3.3707 addresses a waiver process for an insurer to offer preferred and exclusive provider benefit plans in service areas where the insurer's network does not fully comply with the network adequacy requirements.

The commenter observes that the section requires specific information regarding contracting efforts and expected costs in a waiver filing for each county in which the insurer has a mileage gap for a specialty, if there is one or more licensed provider of that specialty available. The commenter says this provision will add significant administrative obligations for insurers in the event a specific provider type is unwilling to contract in a particular service area or when there is no provider of that type located in the area.

The commenter is also concerned with this significant expansion of regulatory involvement in the provider negotiation and contracting process.

The commenter points out that with §3.3707 the department is creating greater obligations for preferred and exclusive provider benefit plans than the department currently applies to health maintenance organizations.

A second commenter also says that the waiver provisions of §3.3707 put preferred and exclusive provider benefit plans at a disadvantage compared to health maintenance organizations. The second commenter says that it appears the department has taken ideas from Insurance Code Chapters 843 and 1305 and grafted them in to Insurance Code Chapter 1301. The commenter asks the department to reconsider the burden this creates.

Agency response: The department does not agree that the amendments to §3.3707 are a significant expansion of regulatory involvement in the provider negotiation and contracting process.

Through Insurance Code §§1301.005, 1301.0055, and 1301.006, the legislature has required that insurers offering preferred provider benefit plans maintain adequate networks of contracted providers. The failure of an insurer to offer an adequate network constitutes a violation of these Insurance Code provisions, and it is an administrative violation under the preferred provider benefit plan rules.

To the extent that there is an inadequacy in the network, the waiver and access plan are necessary so that the department can ensure that any deviation from the network adequacy standards are for good cause as required under Insurance Code §1301.0055(3). In addition, §3.3707 implements the requirement in Insurance Code §1301.006 for an insurer marketing a preferred provider benefit plan to contract with physicians and providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided are provided in a manner ensuring the availability of accessibility to adequate personnel, specialty care, and facilities. The application for waiver and access plan are necessary to enable the department to monitor and ensure compliance with this requirement.

The department created the waiver process in §3.3707 to give insurers a way to offer preferred and exclusive provider benefit plans to insureds who live in areas where there are insufficient numbers of providers to contract with, without violating network adequacy requirements. As adopted, the section permits insurers an opportunity to obtain a waiver of network adequacy requirements, as contemplated by §1301.0055 of the Insurance Code.

Though the department has not previously focused on preferred provider benefit plan network adequacy, the legislature's recent directives are clear. Insurers seeking to market network-based products in particular service areas must have adequate networks in those areas; otherwise they must either cease marketing or obtain waivers from network adequacy requirements.

The department agrees that insurers seeking to continue offering network products in geographic areas where they have inadequate networks will face increased administrative costs - due to filing waiver requests - over the current market, which previously has been virtually unregulated. However, these added costs can be mitigated by other potentially cost-saving factors in the rule. The department notes that in response to another comment it has clarified the time frame that applies for an insurer to address termination of provider contracts. As adopted, §3.3707(i) allows an insurer 90 days from the date a network becomes inadequate to file for a waiver. This will give insurers time to contract with new providers to fix a network inadequacy and will also permit the consolidation and presentation of multiple waiver requests at the same time.

In addition, the regulatory burden is less in areas where providers of a particular type of health care are not available to negotiate and contract with. For these areas an insurer would not need to describe its attempts to contract with providers of the particular health care type. The insurer would also not need to describe savings the insurer would realize by not contracting. The insurer would only need to notify the department that a provider is not available to contract with. If no providers become available in the area, renewal requests would only need to verify that fact.

In areas where providers are available to contract, the department believes it is reasonable for an insurer in its waiver request to demonstrate that it has tried to contract with the providers and to explain why these attempts have failed.

Section 3.3707 does not add to the negotiating or contracting process that occurs between insurers and providers. Instead, it provides the opportunity for insurers to offer preferred or exclusive provider benefit plans in areas of the state where insurers are otherwise unable to contract with all the necessary providers to build a network.

The information required by §3.3707 directly relates to an insurer's attempts to negotiate with providers. It also directly relates to savings the insurer will realize if the department grants a waiver from network requirements. This gives the insurer an opportunity to show the department good cause for it to grant a waiver as required under Insurance Code §1301.0055(3).

In response to the commenters' concern that §3.3707 creates a greater obligation for preferred and exclusive provider benefit plans than the department currently applies to health maintenance organizations, the department may consider examining the requirements applicable to health maintenance organizations in the future. However, this examination is beyond the scope of these rules and is not addressed here.

In addition, health maintenance organizations are generally regulated more closely by the department. For example, health maintenance organizations are examined by the department every three years for various issues, including network adequacy. Preferred and exclusive provider benefit plans are not subject to the same level of oversight. Additionally, the legislature has not included the same language regarding good cause to deviate from network adequacy requirements in the statutes regarding health maintenance organizations as it has in the preferred and exclusive provider statutes. It follows from these differences that the regulations applicable to health maintenance organizations and exclusive provider benefit plans would not be identical.

Comment: A commenter says it is imperative that exclusive provider benefit plans be robust enough to provide all covered services within a reasonable time and distance from insureds, because they provide no out-of-network benefits. The commenter has previously advocated that exclusive provider benefit plans not be granted waivers under §3.3707 and recommends that the section be revised to allow waivers for exclusive provider benefit plans but hold them to a higher standard than applies to preferred provider benefit plans.

Agency response: The department disagrees with the comment and declines to make a change.

The network adequacy standards adopted by the department are largely the same for all network-based products, including health maintenance organizations and preferred and exclusive provider benefit plans. This permits administrative efficiencies for insurers and the department in reviewing networks health benefit plan issuers use in different products.

The department intends to strictly review all waiver requests for preferred and exclusive provider benefit plan networks. However, in the context of an exclusive provider benefit plan, the rule provides additional protection for insureds receiving out-of-network care where no network provider is available.

Section 3.3725 requires that an insurer protect insureds from balance billing in the situations addressed by the section. In most cases, insureds will only need to pay their coinsurance and co-payment amounts.

This additional requirement on insurers offering exclusive provider benefit plans, which is similar to protections afforded enrollees in health maintenance organizations, provides sufficient protection for consumers while encouraging insurers to continually enhance network adequacy.

Section 3.3707(a)

Comment: A commenter opposes the department's proposed amendment to §3.3707(a), which the commenter says would legitimize and permit inadequate networks where an insurer's business plan calls for expansion. The commenter says that an insurer must be able to demonstrate that it has an adequate network before marketing or offering a product, to avoid misleading or deceiving consumers.

The commenter urges the department to not adopt the amendment to §3.3707(a).

The commenter says that if the department does move forward with the amendment, it should require that an insurer give prominent notice to consumers that the product does not fully comply with regulations. The commenter says that as part of this notice to consumers, the department should retain the limited hospital care network designation provisions in §3.3705.

Agency response: The department disagrees with the comment and declines to follow the suggestion to not adopt the amendment.

The amendment to §3.3707(a) does not create a new ability for insurers to expand into service areas even though they have inadequate networks. The amendment clarifies the existing provision which, prior to the proposed amendment, already allowed insurers to apply for waivers from network adequacy requirements, as required by Insurance Code §1301.0055.

Some counties in Texas do not have health care providers for certain specialties. For these counties, the issue is not a matter of insurers not wanting to come to a fair agreement with providers for that specialty, but rather that no provider is available for the insurer to attempt to contract with at all. In such instances, the network adequacy requirements of §3.3704 would prevent the county from being included in a network. This would do harm to consumers in that county, because it would limit their access to insurance. It is necessary that insurers wishing to establish networks that include those counties have the ability to apply for a waiver from network requirements under §3.3704.

Under §3.3707(a), an insurer must file a request for waiver where necessary to avoid a violation of the network adequacy requirements of §3.3704 in a county that it wishes to include in a service area, and under §3.3707(c), the insurer must file a local market access plan with the department to be taken into consideration in determining whether to grant the waiver request. If the waiver request is not granted, inclusion of the county in the service area would be a violation of §3.3704. Thus, the local market access plan for the county would not be used.

Under §3.3707(i), if the status of a network used by a health benefit plan changes so that the health benefit plan no longer complies with §3.3704, the insurer must establish a local market access plan and apply for a waiver under §3.3707(a) for department approval to continue to use it.

The department would take action an insurer that operates out of compliance with the department's regulations. In addition, in response to another comment, the department has withdrawn the proposed removal of provisions that allow for designating networks as "limited hospital care networks."

Section 3.3707(d)

Comment: A commenter opposes the provision in §3.3707(d) that allows an insurer to redact information from the waiver request copy the insurer provides to a provider or physician where sharing the information with the provider or physician would violate state or federal law. The commenter says this provision gives an insurer unilateral authority to decide what information can be legally disclosed.

The commenter says this would allow an insurer to shield information that could be disclosed to a physician that the physician might need to refute assertions the insurer makes about the physician's reasonableness in refusing to contract with the insurer.

The commenter says the provision in §3.3707(d) would severely impair a physician's ability to draft a proper and fully-informed response to an insurer's request for waiver, would silence opposition to the insurer's waiver, and would lead to department grants of more waivers than are appropriate.

The commenter says the department previously said a physician's input is necessary for consideration of a waiver, but that adoption of §3.3707(d) is a retraction of that statement. Section 3.3707(d) would create a one-sided waiver process and act as a loophole in the compliance framework.

The commenter says waiver requests will not generally contain information that could implicate state or federal laws, so the need for a redaction provision is unclear.

The commenter asks that the department strike the redaction provision from §3.3707(d).

As an alternative to striking the redaction language, the commenter says that the department should revise §3.3707(d) to allow the department to determine whether an insurer can legally disclose information in a waiver request. If an insurer specifically asserts that information cannot be disclosed, the department should request that the Antitrust Division of the Office of the Attorney General review it. The commenter adds that, in instances where an insurer says information cannot be legally disclosed, the department should require the insurer to cite the specific federal or state laws that prevent disclosure.

Agency response: The department disagrees with the comment and declines to make a change.

Section 3.3707(d) does include provisions to act as a check on an insurer's redaction of information. It does not give an insurer unilateral authority to determine what waiver request information a provider or physician can receive.

Section 3.3707(d) requires an insurer to give the department a copy of the redacted version of the insurer's waiver request. The department will have the ability to review redactions, and take action against an insurer that inappropriately redacts information under §3.3707(d).

Because the department will have both the full and redacted versions of the insurer's waiver request, any person will be able to make an open records request for the records. The department will follow legal procedures for responding to open records re-

quests. It will provide all the information it can under the Texas Public Information Act, Government Code Chapter 552. Where a possible exception exists, the department will refer the request to the Office of the Attorney General. If, as the commenter says, waiver requests will generally not contain protected information, then it is possible the redaction provision in §3.3707(d) will not be used by insurers. However, the department believes that the provision is necessary because of the detailed information about attempts to contract that an insurer must include in a waiver request.

Under the Texas Public Information Act, some information that the department requires in waiver requests may fall under an exception to disclosure requirements. If this is the case for information included in a wavier request, the department would not be able to disclose it. However, the intent of the exceptions in Government Code Chapter 552 would be thwarted if a department rule required an insurer to directly disclose information covered by those exceptions to other parties. A disclosure requirement could also have a stifling effect if the department required an insurer to disclose all information in a waiver request to a provider because insurers might not include relevant or necessary information that should be protected under law. This could result in denial of an otherwise valid waiver and reduced availability of health insurance to consumers in areas where a waiver is necessary due to the lack of providers willing to contract with insurers.

The department does not agree that additional revisions are necessary to enable department verification that information is exempt from disclosure. Further, the department does not agree that the rule should require insurers to specifically cite federal or state laws that prohibit disclosure.

Section 3.3707(f)

Comment: A commenter supports the language in §3.3707(f), which says the department will post "information relevant to the grant of a waiver" and specific pieces of information on the department's website. The commenter asks that the department specify in the rule the reason or reasons the department found good cause to grant the wavier and any relevant supporting materials, and information on how a person may obtain or view the local market access plan.

Agency response: The department appreciates the comment in support of §3.3707(f), but declines to make the requested change. The department does not agree that the subsection must list additional information that will be posted on the department's website. The department declines to make the requested change.

The use of the word "including" indicates that under the provision the department may post additional relevant information on the department's website. Additional relevant information could include the information requested by the commenter.

Section 3.3707(g)

Comment: A commenter notes that the commenter supported the provision in §3.3707(g) of the withdrawn proposal that would have prevented exclusive provider benefit plans from applying for a waiver from network adequacy requirements. The commenter observes that the exclusion was not included in the current rules.

The commenter understands that there are regions in the state where certain provider types are not present and says that the department should only grant a waiver to an exclusive provider benefit plan in instances under §3.3707(a)(1) where no provider is available to contract.

The commenter says that the rule appropriately holds an insured harmless if the insured is covered by an exclusive provider benefit plan and gets out-of-network care when no preferred provider is reasonably available. The commenter says this should provide good motivation for insurers to have adequate networks.

Agency response: The department disagrees with the comment and declines to make the requested change.

The network adequacy standards the department adopts are largely the same for all network-based products, including health maintenance organizations and preferred and exclusive provider benefit plans. This permits administrative efficiencies for insurers and the department in reviewing networks that health benefit plan issuers will use with different products.

The department intends to strictly review all waiver requests for preferred and exclusive provider benefit plan networks. Additionally, in regard to exclusive provider benefit plans, the rule provides additional protection for insureds receiving out-of-network care where no network provider is available. Section 3.3725 requires that an insurer protect insureds from balance billing in situations addressed by the section. Thus, insureds will, in most situations addressed by §3.3725, only be required to pay their coinsurance and co-payment.

This additional requirement for insurers offering exclusive provider benefit plans, which is similar to protections afforded enrollees in health maintenance organizations, provides sufficient protection for consumers while encouraging insurers to continually enhance network adequacy. The department does not believe it is necessary to exclude the possibility of waivers for an insurer offering an exclusive provider benefit plan, if the insurer is unable to contract for an adequate network.

The department does not believe that the ability of an exclusive provider benefit plan to market in a service area should be contingent on the reasonableness of the contracting positions of necessary providers. The department will review the access plan submitted by the insurer to determine whether insureds will be adequately protected if a waiver is granted.

Section 3.3707(g) and (h)

Comment: A commenter objects to the proposed amendments in §3.3707(g) and (h). The commenter agrees with the department's goal of providing clear application and renewal deadlines, but does not support the amendments the department makes to achieve this.

In regard to §3.3707(g), the commenter objects to the deletion of the requirement that an insurer file its annual waiver renewal application at the same time that it files its annual network adequacy report. The commenter says that it is imperative that an insurer file waiver renewal applications in conjunction with annual network adequacy reports so that the department has up-to-date information about the network composition and a clear picture of its current status.

Because of this, the commenter opposes the language stating that "application for renewal of a waiver must be filed in the manner described in subsection (b) of this section at least 30 days prior to the anniversary of the department's grant of waiver." The commenter asks that the department decline to adopt this language and instead maintain the language requiring filing in conjunction with the annual network adequacy report.

In regard to §3.3707(g)(3), the commenter is opposed to the language that states "a waiver granted by the department will remain in effect unless the insurer fails to timely file an annual application for renewal of the waiver or the department denies the application for renewal."

The commenter says this provision will allow waivers to continue indefinitely if the department fails to act on or deny applications for renewal. The commenter says a framework that allows perpetual waivers does not comply with Insurance Code §1301.0055, which says the department can only allow an insurer to depart from local market network adequacy standards on a showing of good cause.

To address the commenter's concerns, the commenter suggests the department adopt the following text in §3.3707(g) and (h), in place of the proposed text:

(g) An insurer may apply for renewal of a waiver described in subsection (a) of this section annually at the same time the insurer files the annual network adequacy report required under §3.3709 of this subchapter (relating to Annual Network Adequacy Report; Access Plan).

(h) A waiver will expire:

(1) one year after the date the department granted it if an insurer fails to timely request a renewal under subsection (e);

(2) upon the department's denial of the insurer's timely filed request for renewal; or

(3) automatically 90 days after a timely filed request for renewal if the department fails to affirmatively grant or deny the renewal prior to the expiration of 90 days.

Agency response: The department disagrees with the comment and declines to make the change.

The department does not agree that it is necessary for insurers to file waiver renewal applications with annual network adequacy reports because the network adequacy reports will only contain general information by region. The limited information in the annual report is useful for the department to determine where problems might exist in the insurer's network, but it will generally not be relevant to the determination of whether the department should grant a waiver.

Even to the extent annual report information is relevant to the waiver decision, the department does not believe that its decision would be materially affected by having the information at the time of the waiver request rather than having information no more than a year old. If the department does need specific, up-to-date information to evaluate a waiver request, the department has the authority to request it from the insurer.

The department must balance its need for concurrent waiver renewal requests and annual network adequacy reports against stakeholders' need for timely responses from the department to waiver requests. Given the possibility that insurers may file numerous waiver requests with the department, it would be difficult for the department to resolve all waiver requests from insurers in a timely manner if they were all received at the same time April 1, when annual reports are due.

Regarding the comment on the provision in §3.3707(g)(3), which states that a waiver will remain in effect until no timely renewal is filed or the department denies the renewal, the department notes that it intends to actively assess waiver renewal applications. Because it is impossible to tell how many renewal applications will come in each month and how many staff will be available to review the applications, it is not possible to provide a deadline for review by the department. Accordingly, while the department reviews the waiver renewal application, the rule permits insurers to rely on previously granted waivers until the department reviews and acts on the waiver renewal application. If the department determines that it should deny a waiver renewal request after reviewing it, the department will issue a denial. This includes situations where changes in circumstances occur so that the waiver is no longer warranted.

Section 3.3707(i)

Comment: A commenter says that §3.3707(i) will create a "file and use" system for local market access plans. The commenter says that the section requires insurers to establish a local market access plan if the status of the insurer's network no longer complies with network adequacy requirements. The commenter says that the section also specifies details about the plan and requires that the insurer submit the plan as part of the report on network adequacy. The commenter says the department does not express intent to approve a local market access plan before an insurer can use it.

The commenter says that there is no indication that the department takes any interest in ensuring that a local market plan will protect insureds and that the department appears satisfied to rely on the honorable intentions of insurers. The commenter urges the department to approve local market access plans prior to their use.

Agency response: The department disagrees with the comment and declines to make a change based on the comment. While the time frame established in the adopted section permits an insurer to use a local market access plan temporarily before department approval, it does require that the insurer apply for and receive a waiver to continue to use the plan beyond the short period permitted by rule. This is a heightened requirement over the rules adopted May 19, 2011, which did not require a waiver to use a local market access plan and did not address department approval of local market access plans.

Section 3.3707(i) requires an insurer to apply for a waiver for department approval to use a local market access plan. The section addresses situations where an insurer currently has an approved network for a service area, but the status of the network has changed so that it no longer complies with the network adequacy requirements of §3.3704. When this happens, 3.3707(i) requires the insurer to do two things: 1) establish a local market access plan, and 2) apply for a waiver under subsection (a) of the section requesting that the department approve use of the plan.

In response to another comment, the department revises the text of §3.3707(i) to clarify the time frame for an insurer to address termination of provider contracts. As adopted, §3.3707(i) allows an insurer 30 days from the date of termination of the contract to initiate an internal access plan; and it allows 90 days to either rectify the network inadequacy by contracting with new providers, reduce the service area, or apply to the department for a waiver of network adequacy requirements due to inability to contract with providers.

Before approving a waiver, the department will determine that the insurer has arranged through its access plan adequate alternatives for insureds dealing with network inadequacies. Given

the structure of the rule, no separate formal approval of the access plan is necessary.

Consistent with Insurance Code §1301.0055(3), the commissioner will only grant a waiver for continued use of a local market access plan if good cause exists for the waiver. If an insurer attempts to use a local market access plan without a waiver, the insurer would be violating the network adequacy requirements of §3.3704.

Comment: A commenter observes that §3.3707(i) requires insurers to submit a local market access plan within 30 days of identifying a network access gap. The commenter asks what happens if two network access gaps are identified within a 30-day period, and whether a consolidated access plan should be filed to address them.

The commenter recommends that the department move away from continuous monitoring and reporting, and instead move to periodic monitoring and reporting.

The commenter also suggests that the department build in reasonable time frames for payers to identify and address network gaps.

Agency response: The department agrees in part and disagrees in part with the comment. The department has revised the section as adopted to permit an insurer additional time to file a waiver request.

An insurer that does not comply with the network adequacy requirements of §3.3704 commits an administrative violation and is subject to administrative action by the department.

As proposed, §3.3707(i) gave insurers 30 days to institute a local market access plan for adversely impacted insureds. An insurer must quickly establish an access plan when the insurer's network becomes inadequate, to avoid harm to consumers who purchased the product based on its provider network at the time of purchase. The proposed section also specified that an insurer must apply for a waiver under subsection (a) of the section requesting that the department approve use of the local market access plan. However, it did not address the time frame for requesting the waiver. The department agrees to revise §3.3707(i) to clarify this time frame.

As adopted, §3.3707(i) allows an insurer 30 days from the date of termination of the contract to initiate an internal access plan and 90 days to either rectify the network inadequacy by contracting with new providers, reducing the service area, or applying to the department for a waiver of network adequacy requirements due to the inability to contract.

This clarification of the time frames in the rule adequately balances the needs of consumers for adequate networks against the administrative burdens of insurers offering network products. Allowing 90 days gives insurers a window to negotiate with providers and either remedy the violation or develop support for the waiver request. It also sets a limit on how long an insurer can rely on an incomplete provider network without clear department approval of a waiver from the network adequacy requirements.

Insurers may file waiver requests and access plans addressing multiple network issues.

Section 3.3707(i)(1)

Comment: A commenter is confused by the language in §3.3707(i)(1), which requires an insurer to make its local market access plan available to the department upon request. The commenter says that several provisions in §3.3707 instruct an insurer on how to file a waiver request. The commenter says this requires that insurers file a local market access plan with a waiver request.

Agency response: The department acknowledges that the requirement that insurers make their local market access plans available to the department upon request is duplicative and unnecessary, because insurers must submit their local market access plan with a waiver request. The department has not included this requirement in §3.3707(i)(1) as adopted.

Section 3.3707(k)(1)

Comment: A commenter says that §3.3707(k)(1) requires an insurer to identify requests for preauthorization of services for insureds that are "likely to" require services by non-contracted providers and furnish a pre-service estimate of the amount the insurer will pay the physician or provider.

The commenter says the requirement to provide an estimate is not warranted, because the preauthorization process generally does not require the provider to supply the detailed level and amount of information necessary to provide a cost estimate. The commenter says this requirement would be more appropriate for rules under Insurance Code Chapter 1456, which addresses obligations to provide cost estimates to insureds, but that current law does not provide authority for these requirements.

Agency response: The department disagrees with the comment and declines to make a change based on it.

The department notes that the requirement in adopted §3.3707(k)(1) is limited to the narrow circumstance where no network provider is available, and that Insurance Code §1301.005 requires that insurers make preferred providers reasonably available. The department believes that where an insurer does not make preferred providers available in a service area, additional consumer protections are necessary.

Because preferred providers may not balance bill a consumer, estimates of what an insurer will pay are not as useful to patients. However, when the inadequacy of a network requires an insured to use a non-network provider, it is important that the insured be aware of how much the insurer will pay for the proposed procedures.

The department notes that the preauthorization process is administered by the insurer, who may request additional information necessary to provide a good-faith estimate. Insurance Code Chapter 1456 addresses different issues than §3.3709, and it is limited to facility-based physicians even if no access plan applies and there is no network inadequacy. The requirement in the rule that an insurer must establish and implement documented procedures to provide cost estimates applies in all inadequate network situations as a consequence of the network. Compliance with the rule will generally constitute compliance with the estimate requirements found in Insurance Code Chapter 1456.

Section 3.3708(b)

Comment: A commenter references the department's intent that under §3.3708(b), when an insured receives services from a nonpreferred provider and the insured pays a balance bill, the insurer must credit the full amount paid by the insured to the insured's deductible and annual out-of-pocket maximum applicable to in-network services. The commenter says that, as amended, §3.3708(b) does not achieve this.

The commenter says the department's description of the credit an insurer must give an insured is open to several interpretations and could result in different administration by different insurers.

The commenter supports maintaining §3.3708(b) as it existed prior to the proposal, asserting that the previous text would better protect insureds who do not voluntarily choose to obtain services from nonpreferred providers by giving the insureds credit for their actual out-of-pocket expenses in the same manner they would receive a credit if they had received services from a contracted preferred provider.

Agency response: The department agrees in part with the comment. The department declines to withdraw the proposed amendment to §3.3708(b). Instead, the department revises the text of §3.3708(b) to clarify the ambiguity the commenter identifies.

As adopted, the department removes the phrase "in excess of the allowed amount" from the text proposed for §3.3708(b) and inserts the words "charges for covered services that were above and beyond." Under this language an insurer must credit the full amount paid by an insured to the insureds deductible and out-of-pocket maximums.

Section 3.3708(b) and 3.37025(d) - (e)

Comment: A commenter commends the department's proposal of §3.3708(b) and §3.3725(d) - (e). The commenter says the legislature intended to address the problem of inadequate networks with HB 2256 and HB 1772, and that §3.3708(b) and §3.3725(d) - (e) accomplish this intent.

Agency response: The department appreciates the supportive comment.

Section 3.3708(b)(1)

Comment: A commenter says that §3.3708(b)(1) creates a new obligation for insurers to pay some out-of-network charges at "usual billed charges." The commenter says this provision was a surprise and that the department proposed it without sufficient stakeholder involvement or consideration on the cost impact to Texas consumers and employers.

Agency response: The department does not agree with the comment and declines to make a change based on it.

The rule does not require payment of any claims at "usual billed charges," though §3.3708(b) does require that an insurer pay a claim based on a minimum of usual or customary charges when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured. The department does not agree that insufficient stakeholder involvement or cost consideration has been considered regarding the proposed rule. The department has been involved in discussions of out-of-network payment rates since the enactment of SB 1731, 80th Legislature, Regular Session, 2007. Further, the department conducted a second proposal period for these rules to ensure stakeholders had notice and opportunity to comment on all aspects of the final proposed and adopted versions.

Comment: A commenter provides a detailed actuarial analysis addressing the potential cost impact of §3.3708(b)(1).

The commenter says the analysis finds that the proposal would increase total health care costs between .28 percent and .91 percent if networks remain the same and up to 2.6 percent if all hospital-based providers terminated their contracts to maximize revenue. According to the analysis, this projected cost is higher than the cost of most Texas-mandated benefits and could result in increased premium costs for insureds ranging from $20 to $500 per year.

The commenter suggests that the department decline to adopt the proposed provision, add a requirement for insureds to notify insurers if they are balance billed, and defer the issue of reimbursement for out-of-network services to the Texas Legislature.

Agency response: The department does not agree with the comment and declines to make the requested change.

The actuarial analysis provided by the commenter relies on assumptions the department does not believe to be the case, and it does not recognize a number of factors that the department considers relevant.

Though the actuarial analysis recognizes that the rule only requires insurers to pay at the usual and customary rate when there are no available network providers and in cases of emergency, the analysis estimates the cost of the rule based on the assumption that "all out-of-network hospital-based physicians would be paid at usual and customary fee levels." This assumption ignores the fact that, in preferred provider benefit plans, consumers may voluntarily seek out-of-network care, which would not be paid at the usual and customary rate under the rule.

The report also does not take in to account the measures that health maintenance organizations have taken to address similar issues. In particular, health maintenance organizations must pay emergency and inadequate network claims at the full billed charge or an agreed rate. Some health maintenance organizations have taken this into account by operating service areas only where they can provide an adequate network. Health maintenance organizations report that a higher percentage of their claims from facility-based physicians are in-network, as compared to preferred provider benefit plans. See tdi.texas.gov/reports/life/documents/hlthnetwork409b.doc. This indicates that health maintenance organizations have been successful in contracting with out-of-network physicians.

The department reviewed rates that health maintenance organizations and preferred provider benefit plans have filed with the department, and health maintenance organization rates are generally equivalent to or lower than preferred provider benefit plan rates. It does not appear that similar requirements have substantially impacted health maintenance organization rates.

The commenter's actuarial report also does not take into account other aspects of the rule that may have an impact. The adopted rule will require that insurers and insureds receive notice when the insured is being referred out of network.

Insureds will also be given much more information about their networks on which to base their decisions of where to seek care, they will be able to determine the hospitals that are more likely to provide assistance with finding in-network care, and they will better be able to avoid or negotiate out-of-network care. They will be motivated to seek in-network care because they will be responsible for their coinsurance portion of the usual and customary amount.

Additionally, the rule imposes network adequacy requirements that will result in much more robust networks and greatly reduced incidences of out-of-network services being rendered. The rule also creates a process where an insurer may submit information to the department showing that a provider's contract negotiating

position is unreasonable. This may impact negotiations and lead to contracts with more providers.

For all these reasons, the department believes that the actuarial report overestimates the impact on premium of the rule. The department has weighed the potential costs against the statutory requirements and the potential harm to consumers and has concluded that the provision should be retained.

Comment: A commenter observes that §3.3708(b) provides mitigation of balance billing for insureds forced to seek emergency care from nonpreferred providers because of inadequate preferred provider plan networks.

The commenter says the "usual or customary" language in §3.3708(b)(1) provides valuable clarification to ensure that plans cannot circumvent the requirements of Insurance Code §1301.155 by providing unreasonably low reimbursements. Without the clarifications of §3.3708(b), the protections to insureds under Insurance Code §1301.155 would be rendered null, and insureds would suffer hardships from balance bills resulting from unreasonably low reimbursements.

Agency response: The department appreciates the supportive comment.

Comment: A commenter observes that §3.3708(b)(1) requires an insurer to pay a claim based on usual and customary charges when an insured receives services from a non-network provider because no preferred provider is reasonably available. The commenter says the preamble to the rule proposal indicates a new "billed charges" usual and customary standard above and beyond an allowable that refers to Medicare or some other schedule for out-of-network charges.

The commenter says the proposal preamble indicates this provision is included as a clarification of legislative intent. The commenter says that the legislature has specifically considered and rejected attempts to define the payments required for non-network providers and so the department has no authority to impose this requirement in the guise of a clarification.

The commenter also says that while the department characterizes some insurers' payments as arbitrary, it fails to address the fact that providers are free to charge arbitrary amounts.

A second commenter says the department has strayed from the statutes in proposing a requirement that insurers pay some claims by nonpreferred providers at the usual and customary charge and that §3.3708(b)(1) directly conflicts with Insurance Code Chapter 1301. The first commenter agrees with the second commenter, and a third commenter asserts a similar point, saying that this is not a clarification of the current requirement to pay claims at the preferred provider rate, but rather a new requirement not supported by current law.

The second commenter says the only reference to a "usual and customary" rate is in Insurance Code §1301.053, but that section only applies to emergency care in an exclusive provider benefit plan and does not otherwise apply to other situations involving non-network services.

The second commenter says that if a plan is not an exclusive provider benefit plan, other statutory provisions apply. Insurance Code §1301.005(b) applies to non-network providers and refers to reimbursement levels, not the "usual and customary" rate. Insurance Code §1301.155 applies to emergency care, requiring reimbursement at the preferred level of benefits until an insured can be expected to transfer to a preferred provider.

The second commenter also says that by using the phrase "usual and customary rate" the department has ignored the statutory provisions in numerous parts of Insurance Code Chapter 1301 that provide for payment of a nonpreferred provider at a preferred level if care is not reasonably available from a preferred provider. A preferred level is much different than the term "rate" or the phrase "usual and customary." The concept of payment at a usual and customary rate is nowhere in Insurance Code Chapter 1301, and the legislature has refused to give the department the authority to require payment at the usual and customary rate.

The second commenter says the provision could result in numerous unintended consequences, such as making it more difficult for insurers to contract with hospital-based physicians or inciting preferred providers to cancel or not renew contracts in order to collect undiscounted fees.

A fourth commenter is opposed to the proposed rules because they will increase the costs of health policies for employers and employees.

The fourth commenter says that by requiring reimbursement of some out-of-network services at a usual and customary standard, the department is setting rates and requiring insurers to pay billed charges. The third commenter agrees, saying that it appears the department equates usual or customary charges as the average billed charges for a particular service area.

The fourth commenter does not believe the department has authority to set rates and says that even if the department does have this authority, the rules do not exercise it in a lawful manner. The commenter says that §3.3708(b)(1) will allow providers to set rates for out-of-network services and that this constitutes an unlawful delegation of authority to private parties.

A fifth commenter adds that the rules go beyond what the legislature or the Governor's Office has considered. The commenter says the rules should be withdrawn because they create two new out-of-network mandates which would be problematic for businesses and employers that provide employee health coverage.

First, the fifth commenter says the rules do not define the term "usual and customary charges" but that the department's comments in the proposal describe it as being the usual billed charge in a particular area. The fifth commenter opposes forcing insurers to pay billed charges, which are unilaterally set by health care providers and are often unsubstantiated and irrelevant. The commenter says that medical providers commonly bill patients at rates higher than what they actually owe and then use this amount for negotiation, never intending that it be fully paid.

The fifth commenter also says that if the department uses its regulatory authority to force insurers to pay 100 percent of usual and customary charges, providers will raise their billed charges, fewer providers will make agreements with insurers, and the negotiated rates providers reach with insurers will be higher. Insurers forced to pay unsubstantiated billed charges will pass inflated expenses on to employers.

Second, the fifth commenter says that the proposed rules require an insurer to apply the amount paid to the in-network deductible and out-of-pocket maximum, if an insured pays billed charges and provides proof of payment to the insurer. This additional mandate undermines an insurer's ability to underwrite policies and creates uncertainty, which leads to higher prices for insurance policies. The ability of insurers to contract on behalf of employers is the main reason employers are able to offer affordable coverage. The fifth commenter asks what will incentivize

providers to join networks if the department adopts the proposed rules and insurers are no longer able to negotiate contracts.

The fifth commenter asserts that the department attempts both rate setting and unlawful delegation of state authority in the proposed rules. Requiring insurers to pay usual and customary charges for out-of-network services in emergency situations or when no network provider is available is rate setting. It is also a delegation of authority, because the department describes "usual and customary" as usual billed charges, which permits providers to set their rates at any amount and determine the fees they will collect from insurers.

The fifth commenter concludes by saying that if the department adopts the proposed rules, employers and their employees will ultimately pay the price for them through higher health care premiums and co-pays, and reduced wages or benefits.

Agency response: The department disagrees with the comments and declines to make a change because the proposed language is necessary to reduce incidences of balance billing in cases where consumers have no choice regarding out-of-network care. The department contends that the rule conforms to statutory requirements applicable to preferred provider benefit plans.

The department bases the requirement that an insurer pay a claim based on usual and customary charges when an insured receives services from a non-network provider because no preferred provider is reasonably available on its interpretation of Insurance Code §1301.005(b) and §1301.155(b).

Insurance Code §1301.155(b) requires that an insurer reimburse emergency care services at the preferred level of benefits, if an insured cannot reasonably reach a preferred provider, until the insured can reasonably be expected to transfer to a preferred provider.

HB 1772 provides additional guidance by adding Insurance Code §1301.0053 in the context of exclusive provider benefit plans. It clarifies that an insurer must reimburse emergency care under Insurance Code §1301.155 at the usual and customary rate or a rate agreed to by the insurer and the nonpreferred provider. Because Insurance Code §1301.155 is ambiguous in defining what constitutes the "usual and customary rate," it is necessary for the department to do so by rule in order to provide for uniform application of the chapter and uniform access to benefits under the chapter by insureds.

Although the focus of HB 1772 was the addition of new exclusive provider benefit plans to the network-based insurance products an insurer may offer in Texas, the clarification of an insurer's duty under Insurance Code §1301.155 accomplished through the addition of §1301.0053 is equally necessary for preferred provider benefit plans. Insureds under these plans are likewise faced with reimbursement of emergency care services for which reasonable access is an issue.

Under Insurance Code §1301.005(b), if services are not available through a preferred provider within a designated service area under an exclusive or preferred provider benefit plan, the insurer must reimburse a nonpreferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed for the services.

Again, HB 1772 provides guidance in the context of exclusive provider benefit plans by requiring the insurer to fully reimburse the nonpreferred provider for medically necessary services not available through a preferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider. While this additional guidance is in the context of a bill focused on exclusive provider benefit plans, the clarification of an insurer's duty under Insurance Code §1301.005 accomplished through the addition of Insurance Code §1301.0052 is equally necessary for preferred provider benefit plans. Insureds under these plans are likewise faced with reimbursement of services for which reasonable access is an issue under circumstances beyond the insured's control.

The department also bases this provision on the requirement of Insurance Code §1301.005(a), which requires that an insurer make out-of-network benefits "reasonably available" to all insureds. The department has received complaints that some insurers pay these claims at rates that are a fraction of usual and customary rates. Support for this position is found in the department's survey of insurers that was part the department's 2009 published report called *Report Of the Health Network Adequacy Advisory Committee, Senate Bill 1731, Section 11 Eightieth Legislature, Regular Session, 2007.* This report is available on the department's website at tdi.texas.gov/reports/life/documents/hlthnetwork09.doc. Table 4 on page 24 of the report illustrates the average allowed amounts for non-network providers by five insurers. Using radiology billings as an example, one insurer paid non-network providers an average of 95 percent of their billed charges. Another insurer paid 38.7 percent, leaving insureds responsible for both their share of the 38.7 percent under the insureds' plans and 100 percent of the remaining 61.3 percent. In cases of large bills, such low reimbursements could result in an insured with major medical coverage being responsible for paying the bulk of the billed charge, an amount that in some cases could make the out-of-network benefits effectively unavailable.

The rule clarifies the legislature's intent in requiring payment of these particular claims at the preferred level by specifying that the calculation must be based, at a minimum, on the usual and customary rate for such services, rather than any lower amount chosen by an insurer. By requiring payment at the usual and customary rate in situations where an insured has no choice in whether to see an out-of-network provider, either due to an emergency or the insurer's failure to provide an adequate network, the statute and this clarifying rule give the insured some certainty in the insured's insurance coverage and financial security. Consistent with the nature of insurance, the insurer bears the risk of balance billing instead of the insured.

By setting a benchmark of usual and customary, the rule ensures that consumers can make more informed decisions when choosing their health plan coverage with some confidence of consistency on this potentially enormous financial issue, and it allows them to better understand the financial consequences of their health care decisions. Insurers are still able to set the coinsurance percentage to be applied to the usual and customary charge.

Recognizing the potential impact on premiums, the department has determined that the use of "usual and customary" will not be required when an insured voluntarily chooses to seek out-of-network care. Instead, insurers must only utilize this benchmark in cases where the insured has no choice in receiving out-of-network care, in cases of emergency, and in cases where the insurer has no available contracted providers in the network. Due to the increased requirements for network adequacy in the rule, the department expects that the three situations previously described will occur far less frequently than in the past, significantly reduc-

ing the occasions when an insurer must utilize usual and customary as the baseline. Because these situations will be relatively rare, the department believes that insurers will be able to actuarially anticipate the financial impact of insureds seeking credit toward deductible and out-of-pocket maximum for amounts actually paid for out-of-network health care services and those credits actually impacting whether the deductible and out of pocket maximums are met.

The department notes that it has required health maintenance organizations to insulate enrollees from balance billing in these limited situations, yet health maintenance organization premiums are generally comparable to or lower than preferred provider benefit plan premiums in the Texas market. Health maintenance organizations have also been able to maintain adequate networks despite this comparable requirement.

Insurers are not required to market a network product in areas where they do not contract with adequate numbers of providers. Their choice to do so should not result in their insureds being subject unexpected and substantial balance billing.

When an insurer includes regions in the insurer's service areas where the insurer does not have an adequate network, the rule provides some ability to mitigate out-of-network costs. Specifically, §3.3703(a)(27) and §3.3703(a)(28) require that physicians and facilities provide the insurer with notice of upcoming surgeries. Insurers with inadequate network coverage at the facility where surgery is scheduled will be able to minimize the likelihood of balance billing by working with non-network providers in advance of the surgery, and communicating with the insured to explain any potential out-of-pocket costs.

Neither the rule nor the rule preamble specify what would constitute a usual and customary charge, nor do they attempt to establish a new standard for usual and customary above and beyond an allowable amount in Medicare or some other schedule for out-of-network charges.

Stakeholders across the board accuse each other of arbitrary billing and payment practices. The department does not have authority to regulate the amounts that providers bill for services, so it cannot address arbitrary provider charges by rule. However, the department has previously raised this issue with the legislature. See page 36 of the department's *Biennial Report to the 83rd Legislature,* which can be found on the department's website at tdi.texas.gov/reports/documents/finalbie13.pdf.

The rule does not require that insurers pay providers' "billed charges." Instead, the insurer may determine, subject to the requirements of the rule, what the usual and customary charge for the service is in the geographic area.

Comment: A commenter says that the rules will benefit consumers by greatly reducing incidents of balance billing and by reducing the amounts of balance bills. The commenter says this will be due in part to the addition of §3.3708(b)(1), which requires that preferred provider benefit plans pay claims at the usual or customary charge when no preferred provider is reasonably available. The commenter says that, short of a legislative solution that ends balance billing, the department's approach to minimize balance billing appears to be as protective of consumers as possible.

The commenter addresses concerns of other commenters who say that paying usual and customary rates will reduce the motivation for providers to contract, resulting in increased premiums. The commenter says that the concerns may be overblown, because the rules only address instances where an insured involuntarily receives out-of-network care.

The commenter says that the department needs to maintain a strong standard for the "floor" for payments an insurer pays to out-of-network providers when no preferred provider is available, to encourage insurers to maintain adequate networks and reduce balance bills for consumers. The commenter also says that increased premiums are not as big a concern as getting value for premiums paid, and that a slight increase in premiums is worth it if it means reduced balanced billing.

The commenter says nonpreferred providers do not need to receive full billed charges to be considered paid in full, because balance bills are not always completely collected. So setting the floor at billed charges would result in payment higher than is needed to reduce balance billing. The commenter says that usual and customary provides the best protection against balance billing, which is a meaningful benefit in exchange for any premium increase.

The commenter does not think usual and customary will cause providers to leave networks, because insurer and provider motivation to contract is influenced by many factors. The commenter suggests that the department actively monitor balance billing complaints, requests for mediation, and information submitted through network adequacy waiver requests to identify any trends of providers moving in or out of networks.

Agency response: The department agrees with the comment that it is necessary to set a floor for payments to out-of-network providers in certain circumstances, but that potential negative consequences exist for any floor that is picked, including the potential for higher premiums and higher incidences of balance billing.

The department believes that the proper course is to err on the side of protecting consumers from unexpected balance bills when they have no choice of the provider, while giving consumers and insurers as much opportunity as possible to reduce the frequency of unintentional use of out-of-network providers and the opportunity to negotiate out-of-network charges in advance.

Accordingly, the department makes no change at this time. However, as recommended by the commenter, the department will monitor the impact of these rules and other changes on the market and continue to consider where an appropriate floor should be set. Further, the department has previously raised this issue with the legislature. See page 36 of the department's *Biennial Report to the 83rd Legislature,* which can be found on the department's website at tdi.texas.gov/reports/documents/finalbie13.pdf.

Comment: A commenter responds to a concern raised by other commenters during the public hearing that §3.3708(b)(1) could create a state mandate that the state must pay for under the Patient Protection and Affordable Care Act.

The commenter says that the U.S. Department of Health and Human Services has said that state rules related to provider types, cost-sharing, or reimbursement methods would not fall under its interpretation of state-required benefits. The commenter offers the following quote from the U.S. Department of Health and Human Services:

HHS received many comments in response to the EHB [essential health benefits] Bulletin about how state-required benefits beyond EHB could be identified and how states would defray

the cost of those benefits. In this proposed rule, we interpret state-required benefits to be specific to the care, treatment, and services that a state requires issuers to offer to its enrollees. Therefore, state rules related to provider types, cost-sharing, or reimbursement methods would not fall under our interpretation of state-required benefits. Even though plans must comply with those state requirements, there would be no federal obligation for states to defray the costs associated with those requirements.

Agency response: The department agrees with the commenter that §3.3708(b) does not create a state mandate for which the state must pay.

Comment: A commenter responds to a concern raised by other commenters during the public hearing that the department lacks statutory authority to designate the usual and customary charge for a service as the floor for health insurance claim settlements.

The commenter argues that Insurance Code §542.003 prohibits insurers from engaging in unfair claim settlement practices and that the commissioner has authority to establish what constitutes an unfair claim settlement practice. The commenter says the commissioner could use the authority under Insurance Code Chapter 542 to address claim settlement to ensure that insurers act in good faith to achieve a prompt, fair, and equitable settlement of a claim submitted in which liability has become reasonably clear.

The commenter says that other commenters also testified that requiring payment of nonpreferred providers at the usual and customary rate or an agreed upon rate would lead to increased premiums and unlimited charges by providers. The commenter says this is a baseless prediction. The commenter points out that Insurance Code §§1271.055 and 1271.155 require health maintenance organizations to pay certain out-of-network services at the usual and customary rate or an agreed upon rate, and it has not harmed the market.

The commenter says that the true risk of harm to consumers comes from insurers attempting to push more out-of-network costs onto insureds.

The commenter says that §3.3708(b) creates a regulatory framework which ensures consumers receive a valuable insurance product for their premium, and urges the department to retain it.

Agency response: The department appreciates the commenter's support for §3.3708(b)(1). The department notes that it has addressed its basis for §3.3708(b)(1) in response to a previous summary of comments in this proposal.

Section 3.3708(b)(3)

Comment: Two commenters say §3.3708(b)(3) creates a new requirement for insurers to credit amounts insureds agree to pay nonpreferred providers in "excess" of allowable amounts. Both commenters say this change is not supported by statutory language.

One of the commenters also says it is unprecedented and essentially modifies the definitions of "allowable amounts" that have been in place in approved policy form filings for decades. That commenter says the proposed rule would impair existing contracts that give credit only for amounts paid by an insured up to the "allowable amount" and would require an increased cost that could increase premiums.

The other commenter says emergency care services are an essential benefit under the Patient Protection and Affordable Care Act, and that under federal rules an insurer can require that an insured pay the excess of the amount the out-of-network provider charges over the amount the plan or issuer is required to pay. This means if the department adopts the rule, it would exceed federal health care reform requirements.

Agency response: The department disagrees with the comment and declines to make a change.

Insurance Code §1301.007 requires the commissioner to adopt rules as necessary to implement Insurance Code Chapter 1301. Insurance Code §1301.0055 requires the commissioner to adopt network adequacy standards. Insurance Code §1301.005 and §1301.155 requires that insurers' payment of inadequate network and emergency claims be at the preferred level of benefits.

This shows legislative intent to treat payment of claims where the network is inadequate or in emergency situations similar to in-network claims because of the insured's lack of choice in those situations. Section 3.3708(b)(3) clarifies that an insurer must also treat the payments made by consumers in those narrow situations in the same manner as they would have if they had been for in-network claims.

The department expects it will be uncommon that an insurer will need to credit an insured's out-of-pocket expenses to their out-of-pocket maximum because not all insureds will be balance billed by out-of-network providers under the requisite circumstances, not all of those insureds will actually pay the balance billed amount, not all of those insureds will submit evidence to insurers supporting requests that out-of-pocket amounts be credited to their deductibles and out-of-pocket maximums, and not all of those insureds will reach their deductible and out-of-pocket maximums and then incur additional claims. In addition, many nonpreferred providers negotiate balance bill amounts with insureds. In these cases there would be a further reduction in the out-of-pocket payments made by the insured.

Section 3.3708(b) represents a reasonable balance of interests between the insured, who has no choice in using an out-of-network provider under the narrow circumstances specified in §3.3708(a), and the insurer, whose responsibility it is to have an adequate network.

The department also notes that if an insurer has reason to believe that there is a substantial difference between a physician or provider's billed charges and a reasonable rate of reimbursement, the insurer may attempt to negotiate a reduction in overall charges.

Further, it is the department's position that a major medical insurance policy providing coverage under Insurance Code Chapter 1301 would be unjust and deceptive under Insurance Code Chapter 1701 if it did not provide credit for an insured's necessary and actual out-of-pocket expenses incurred as a result of an inadequate network or in an emergency.

Finally, recent federal guidance indicates that states' rules relating to cost-sharing and reimbursement methods are permitted and will not constitute state benefit mandates. See *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Proposed Rule,* available on the Government Printing Office website at gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm.

Comment: A commenter supports the amendments to §3.3708(b)(3) which clarify that in required cost-sharing and balance billing, an insurer must credit the amount an insured has paid out-of-pocket to the in-network deductible and out-of-pocket

maximum when a preferred provider is not reasonably available. The commenter observes that this scenario will only happen in emergencies or when a network is inadequate.

The commenter responds to a concern raised by another commenter during the public hearing that §3.3708(b)(3) might create a state mandate that the state must pay for under the Patient Protection and Affordable Care Act. The commenter says that the U.S. Department of Health and Human Services has said that states' rules related to provider types, cost-sharing, or reimbursement methods would not fall under its interpretation of state-required benefits.

Agency response: The department appreciates the supportive comment. The department agrees that §3.3708(b)(3) will not result in a state mandate that the state must pay for under the Patient Protection and Affordable Care Act.

Section 3.3708(c)

Comment: In regard to §3.3708(c), a commenter asserts that the department lacks statutory authority to establish standards for reimbursement methodology. The commenter requests that the department delete the provision.

Agency response: The department disagrees with the comment and declines to make a change.

Section 3.3708(c) applies basic standards of fairness to whatever reimbursement methodology an insurer may choose to use for standard out-of-network claims. The rule permits an insurer to base its reimbursements on usual and customary charges, but if it does so, it must use generally accepted industry standards for determining billed charges.

An insurer may base reimbursements on claims data; but if it does so, it must use data that is updated periodically. Further, an insurer must use generally accepted bundling edits and logic when determining how to pay its claims.

An insurer that does not comply with these fundamental requirements would be selling a product that is unjust, encourages misrepresentation, or is deceptive under Insurance Code Chapter 1701. If insurers do not comply with these requirements, insureds will not have confidence that their claims are paid correctly or fairly.

Insurance Code §1301.007 requires the commissioner to adopt rules necessary to implement Insurance Code Chapter 1301. Failure to address the methodology by which out-of-network reimbursement is calculated could adversely affect insureds and providers, particularly if insurers use old data, statistically insignificant samples, or any other information described by §3.3708(c) to calculate out-of-network reimbursements.

Section 3.3708(e)

Comment: A commenter opposes the department's amendment to §3.3708(e). The commenter says the amendment would remove a provision that gives insureds considerable power and that the new text unnecessarily repeats language included in the notices in §3.3705 and misrepresents provisions in Insurance Code Chapter 1467 permitting teleconference and mediation.

The commenter says it is important that insureds not be misled into believing that remedies are available under Insurance Code Chapter 1467 when they are actually unavailable. The commenter says that thresholds set by Insurance Code Chapter 1467 make no mention of the difference between the allowed amount and billed charges. This is an inaccuracy resulting from failure to communicate with stakeholders, and the department does not explain why it wants insureds to receive inaccurate information. The commenter suggests that the department should rely on the notice required under §3.3705(f).

The commenter says that under the version of §3.3708(e) adopted May 19, 2011, an insured receives notice that the insured may request additional pricing information from the insurer. The commenter supports that version of the text because it focuses on transparency and provides useful billing information to insureds. Without payment information, insureds would have difficulty acting as reasonable economic decision-makers.

Because of this, the commenter asks that the department maintain the text as adopted May 19, 2011, and not adopt the proposed amendment. However, the commenter adds that it is acceptable to require that an insurer's explanation of benefits note that information is available under §3.3708(e), so that insureds will know they can access this information.

The commenter also points out that a contract rate does not reflect the price of a medical service. The commenter says that the price is what a physician charges, and the commenter says that a contracted rate is only a fraction of the total economic transfer. The commenter describes ancillary benefits of a contract that add non-cash value to the contracted rate that equates to a provider's billed charge.

The commenter suggests that the department require insurers to offer median pricing information under §3.3708(e) that reflect like places of service. The commenter says that in some cases insurers might set different fee schedules based on place of service and that this should not be reflected in the information offered under §3.3708(e). The commenter says that department should also not allow insurers to use Medicare payment guidelines in determining median pricing information because they are not a reflection of prevailing out-of-network market rates and may fluctuate based on political factors.

The commenter says that, because an insurer only needs to provide information under §3.3708(e) in response to a request from an insured, §3.3708(e) should not pose a burden to insurers.

Agency response: The department disagrees with the comment and declines to reinstate the text proposed for deletion.

The deleted text required insurers to provide payment information for comparison purposes when paying an out-of-network claim in circumstances where no preferred provider was reasonably available. The purpose of the requirement was to provide information to an insured that might be useful to negotiate payment of a balance bill issued by a provider in cases when the insurer paid the claim at an amount that it determined to be allowable, but that resulted in a balance bill.

However, under §3.3708(b), insurers must pay these claims at the usual and customary rate for the services. Because this will largely eliminate balance billing, the department has determined that the administrative cost of the requirement outweighs the relatively small benefit to consumers. As the commenter notes, the contracted rate insurers pay does not reflect the price for a medical service. The contract rate is just a fraction of the economic transaction between the provider and insurer.

Regarding the comment on the proposed new language in §3.3708(e), the department's interest is in making sure insureds are aware of their right to mediation. The rule provides a general guide for when the notice must be given to the insureds, and then directs insureds to more information available on the

department's website. The department does not believe that insureds will be misled by this notice.

Section 3.3709(b)(3)

Comment: A commenter strongly supports retention of §3.3709 as adopted May 19, 2011. The commenter says that the section is the heart of the regulatory framework created by the department for network adequacy purposes and that removal of the section would be a capitulation to insurers' desire to keep the true condition of their networks shrouded from the scrutiny of their insureds and the department. The proposed changes to §3.3709 defeat the purpose of the annual report and indicate a misunderstanding of the value insurers' reports deliver to the department for oversight of insurer marketplace conduct.

The commenter opposes relocating waiver provisions to §3.3707 and urges the department to not strike local market access plan provisions in §3.3709. Retention of §3.3709 would prevent serious network gaps previously identified by the department.

Agency response: The department disagrees with the comment and declines to make a change.

The amendments to §3.3709 and §3.3707 do not alter the information the department will receive in the insurers' annual reports. Under §3.3707(m), an insurer must still file its local market access plan with the annual report under §3.3709, and the provisions addressing the content of the local market access plan are still present in §3.3707(j) - (l). However, relocation of provisions to §3.3707 imposes a higher burden on insurers that would use a local market access plan, because under the adopted section an insurer must request a waiver to continue to use a local market access plan and must provide the department information that supports granting the waiver.

Comment: A commenter is concerned by the administrative burden of the annual report requirement under §3.3709(b)(3).

The commenter says this provision requires an insurer to make a statement regarding whether the network for each of its plans is adequate, but it does not define what constitutes adequate. The commenter notes that §3.3704(e) includes a list of eleven requirements for an adequate network, including the maximum distances to a point of service, but says that the lack of various provider types in different areas of the state make it impossible to meet mileage requirements in all areas of the state.

The commenter says that disclosure requirements based on impossible standards do not take into account the legislature's direction in §1301.055 that network adequacy standards be "adapted to local markets."

The commenter suggests that the department distinguish between areas of the state where no providers are available versus areas where a health benefit plan is unable to obtain a contract with providers.

The commenter thinks the complaint reporting requirement under subsection (c) is unduly burdensome because it requires a new and different categorization of complaints than is provided in the existing complaint record requirements under 28 TAC §21.2504.

The commenter suggests deleting subsection (f), because it is not supported by statute.

The commenter also does not understand the requirement to identify services that are likely to require "directly or indirectly" the services of out-of-network providers, and recommends that the department delete the reference to "indirectly."

Finally, the commenter says the requirement to provide an estimate is not warranted because the preauthorization process generally does not require the detailed level and amount of information necessary to provide a cost estimate. The commenter says this requirement would be more appropriate for rules under Insurance Code Chapter 1456, which addresses insurer obligations to provide cost estimates to insureds.

In addition, the commenter provides a general list of issues that may impact compliance with network adequacy reporting requirements: an insurer can only report network access issues after the insurer has fully processed a provider addition or termination; there is a 60-day notification period before termination of a contract between a provider and an insurer, and in that time the contract might be renewed; there could be delays in receiving timely updates of provider demographic data; providers may not inform insurers of changes in office locations, group practice rosters, or group affiliations; and insurers may run into system maintenance issues or reporting errors.

Agency response: The department disagrees with the comment and declines to make a change.

Insurers seeking to sell preferred or exclusive provider benefit plan products in Texas decide which parts of the state to include in their service area. Insurers that are unable to provide an adequate network to consumers in a particular area should consider whether it is feasible or practicable to market policies there. Insurers that decide to market these types of policies in areas of the state where they have an inadequate network will be subject to additional requirements, beginning with the requirement in §3.3709 that they disclose areas where their network does not meet the network adequacy requirements of §3.3704.

Due to the requirement of Insurance Code §1301.005 that insurers make certain that preferred provider benefits are available to their insureds, it is reasonable for the department to require insurers to disclose this information to the department. The rule accommodates local markets by permitting insurers to obtain waivers of the network adequacy requirements where they are unable, despite due diligence, to obtain contracts with providers.

The reporting requirements in §3.3709(c) are necessary for the department and insurers to monitor whether preferred providers are reasonably available to insureds. A majority of health benefit plan issuers have reported that they do not separately monitor balance billing complaints and inquiries. See page 4 of the *Report of the Health Network Adequacy Advisory Committee: Health Benefit Plan Provider Contracting Survey Results* on the department's website at tdi.texas.gov/reports/life/documents/hlthnetwork409b.doc. Further, less than half of the health benefit plan issuers the department surveyed reported that they have a process for monitoring the extent to which insureds receive treatment from nonpreferred facility-based physicians at preferred provider facilities. See also page 4 of the *Network Adequacy Advisory Report.*

The department notes that the phrase "directly or indirectly" was deleted in the current rule proposal and does not appear in the adopted rule.

Regarding the requirement that an insurer implement procedures in areas where the insurer uses an access plan to furnish insureds an estimate of the amount the insurer will pay non-network providers, the department notes that this requirement is

limited to the narrow circumstance where no network provider is available. Insurance Code §1301.005 requires that insurers make preferred providers reasonably available. The department believes that where an insurer does not make preferred providers available in a service area, additional consumer protections are necessary. Because preferred providers may not balance bill a consumer, estimates of what an insurer will pay are not as useful to insureds. However, when the inadequacy of a network requires an insured to use a non-network provider, it is important that the insured be aware of how much the insurer will pay for the proposed procedures.

The department notes that the preauthorization process is administered by the insurer, who may request additional information where necessary to provide a good-faith estimate. In addition, Insurance Code Chapter 1456 addresses different issues than §3.3709 in that it is limited to facility-based physicians even if no access plan applies. The requirement in the rule for procedures to provide estimates applies in all inadequate network situations as a consequence of the inadequate network provided. Compliance with the rule will generally constitute compliance with the estimate requirements found in Insurance Code Chapter 1456.

Section 3.3710

Comment: A commenter restates opposition to establishment of a "file and use" process for local market access plans. The commenter says that the department should not rely on the intentions of an insurer that is already out of compliance with department regulations, and the commenter suggests additional text for §3.3710 to affirmatively regulate insurers who sell defective products to consumers. The commenter suggests striking the reference to local market access plans in §3.3710(a) and adding the following new subsections (c) and (d):

(c) A local market access plan shall be submitted to the department for approval prior to the implementation of the plan. The commissioner may disapprove a submitted local market access plan only after notice and opportunity for hearing."

(d) The commissioner shall, as soon as practicable, publish in the Texas Register notice of approved local market access plans which includes:

(1) the name of the insurer;

(2) the name of the health benefit plan subject to the local market access plan; and

(3) the specialties or provider type(s) which are addressed by the local market access plan.

Agency response: The department disagrees with the comment and declines to make a change.

The department declines to make the suggested change to §3.3710(a), because the change would reduce the department's ability to take enforcement action for inadequate access plans. If the department removes the reference to local market access plans from §3.3707(a), the section would only address department enforcement actions concerning networks that become inadequate. The section would no longer address notice, opportunity for a hearing, or possible sanctions in instances where an insurer's local market access plan becomes inadequate.

The department declines to add §3.3710(c) as recommended by the commenter because the change would be redundant and would create unnecessary administrative burdens. Insurers are already required to request a waiver for use of a local market access plan under §3.3707. Insurers must provide their local market access plan at the time they request a waiver to use it, so it is unnecessary to add this requirement to §3.3710.

The suggested text would also change the waiver and local market access plan from a department review process to an enforcement process.

The suggested revision could actually create a "file and use" process because the text says the commissioner may not "disapprove" a local market access plan until after a hearing. This could allow for an insurer to argue that its access plan is valid until the State Office of Administrative Hearings issues an order permitting the commissioner to disapprove it.

The department declines to add §3.3710(d) as recommended by the commenter because this change would be redundant and would provide little or no benefit to insureds.

Under §3.3707(f), the department will post information relevant to waivers granted on the department's website. The website could include information related to an insurer's local market access plan, including that listed by the commenter. The department's website is a better place to post information related to a waiver and local market access plan because it is more accessible to most consumers than issues of the *Texas Register.*

Section 3.3721

Comment: A commenter agrees with the requirement in proposed §3.3721 that an insurer establishing an exclusive provider benefit plan should obtain permission from the department before offering exclusive provider benefit plan products in Texas.

The commenter says that the permission should be in the form of a formal certificate of compliance for each exclusive provider benefit plan service area, based on the insurer's ability to create and maintain an adequate network. The commenter says that a certificate would be credible evidence that an insurer has adequate infrastructure and relationships with providers to manage its network successfully.

Agency response: The department agrees that it is important to review and approve exclusive provider benefit plan networks prior to the exclusive provider benefit plan product being marketed in Texas. However, the department does not agree that a formal certificate is necessary and declines to make the requested change.

The department intends to regulate exclusive provider benefit plans similar to how it regulates health maintenance organizations, by approving the exclusive provider benefit plan for operation in specific service areas without a formal certificate.

The department has not observed significant problems with the absence of a formal certificate in the health maintenance organization context. An insurer marketing a plan outside of its approved service area will be subject to administrative action by the department.

Section 3.3722(a)

Comment: A commenter recommends that the department specify minimum required standards for complaint systems. The commenter recommends the following language from an early working draft of the exclusive provider benefit plan rules:

(a) Complaint system required. An insurer is required to implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a

complainant. The complaint system must include a process that complies with the requirements of this section.

(1) Not later than seven calendar days after receipt of an oral or written complaint, the insurer must:

(A) acknowledge receipt of the complaint in writing;

(B) acknowledge the date of receipt; and

(C) provide a description of the insurer's complaint procedures and deadlines.

(2) An insurer shall investigate each complaint received in accordance with the insurer's policies and in compliance with this subchapter.

(3) After an insurer has investigated a complaint, the insurer shall issue a resolution letter to the complainant not later than the 30th calendar day after the insurer receives the written complaint which:

(A) explains the insurer's resolution of the complaint;

(B) states the specific reasons for the resolution;

(C) states the specialization of any health care provider consulted;

(D) states that, if the complainant is dissatisfied with the resolution of the complaint or the complaint process, the complainant may file a complaint with the department; and

(E) includes the department's mailing address, toll-free telephone number and website address.

(b) Record of complaints.

(1) An insurer shall maintain a complaint log regarding each complaint as required by this section.

(2) Each insurer must maintain and make available to the department upon request a complaint log that:

(A) is categorized and completed in accordance with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions); and

(B) includes the following additional categories:

(i) quality of care or services;

(ii) accessibility/availability of services;

(iii) utilization review or management; and

(iv) complaint procedures.

(3) An insurer shall maintain a record of and documentation on each complaint, complaint proceeding, and action taken on each complaint until the third anniversary of the date the complaint was received.

(4) A complainant is entitled to a copy of the record of the complainant's complaint and any proceeding relating to that complaint.

(5) The department, during any investigation of an insurer, may review documentation maintained under paragraph (3) of this subsection, including original documentation, regarding a complaint and action taken on the complaint.

Agency response: The department agrees that insurers issuing exclusive provider benefit plans must have reasonable complaint systems. However, the department does not agree required details and prescriptive rule language is necessary. Such prescriptive requirements have not previously been imposed on health maintenance organizations or insurers offering preferred provider benefit plans.

The proposed rule text requires that insurers provide documentation of a reasonable complaint system. This is similar to the requirement for health maintenance organizations in 28 TAC §11.204. Insurers with exclusive provider benefit plans will also be required to comply with the general complaint record requirements in 28 TAC §21.2504. Insurers with exclusive provider benefit plans will also be required to include in all policies and certificates information on how to contact the department to file a complaint.

Because the department will be reviewing the complaint systems implemented by insurers with exclusive provider benefit plans for reasonableness, and because insureds will have recourse to file complaints with the department, the department declines to make the requested change.

Section 3.3722(c)

Comment: A commenter suggests that the department add additional requirements to the exclusive provider benefit plan approval application.

The commenter suggests that the department require that applications include an attestation sworn to before a notary, rather than just signed by a representative of the applicant, and that the application include a statement that the attesting person knows no reason under the Insurance Code why the applicant is not entitled to approval.

The commenter also recommends that the department require that applications include the form of any agreements the applicant has with third parties to perform management, data processing, or claims processing services; any monitoring plans regarding those agreements; and that new agreements or modifications of current agreements be filed as they are executed or modified.

The commenter also recommends that the department require that applications include all physician and provider contract templates, and also require that the applicant file any amendments made to those templates. The commenter suggests that the department require an attestation when an insurer files forms, to be under penalty of perjury.

The commenter further recommends that the insurer be required to file descriptions of its information systems, management structure, and personnel, as well as updates to the descriptions as they occur, demonstrating the insurer's capacity to meet the needs of insureds, physicians, and providers and to meet the requirements of regulatory and contracting entities.

Finally, the commenter recommends that the department require that the insurer's complaint system have reasonable procedures to resolve oral complaints, in addition to written complaints.

Agency response: The department does not agree with the comment and declines to make a change.

Regarding attestation under penalty of perjury as part of an insurer's exclusive provider benefit plan approval application, the department notes that an application for a health maintenance organization license currently does not require a signature before a notary. In addition, insurers seeking approval to market exclusive provider benefit plan products must have a certificate of authority to operate as an insurer in Texas. The department will already have the ability to take administrative action against

an insurer for false statements. The department will also be able to order corrective action to remedy violations. Finally, the department notes that Insurance Code §841.704 says a material false statement to the department is punishable by imprisonment for not less than one year, regardless of whether the statement is sworn.

Regarding the second recommendation, the department declines to make a change to require filing of all administrative agreements. Insurers are legally permitted to enter into many different types of agreements with third parties, from data input to claims processing. The department holds an insurer ultimately responsible for compliance issues. If issues arise as to particular third party agreements, the department can request additional information, including copies of relevant documents. Requiring insurers to always file, and the department to process, third party contracts that are not necessary to confirm compliance would add additional administrative expense without sufficient justification.

The department declines to require that an insurer file provider contract templates in every case. Section 3.3723 says the department may request copies of any contract with a physician or provider during an examination. Given resource limitations, review of every contract template may not be feasible, making routine filing of every template unnecessary. The department believes that its ability to take administrative action for the submission of false statements and to order restitution to impacted providers is sufficient to deter false statements in this context.

The department declines to require that insurers file descriptions of their information systems, management structure, and personnel, including updates. The listed descriptions are more appropriate to the larger issues of company licensure rather than approval to write a particular type of health insurance.

Regarding the fifth recommendation, the department declines to prescribe requirements for the handling of oral complaints. The department encourages insurers to have strong procedures for resolving oral complaints so that they do not escalate further. However, enforcement of such requirements is problematic, as it is often difficult to prove up what was voiced in an oral complaint, whether it constituted a complaint, and whether the insurer responded appropriately.

Section 3.3722(c)(4)(B)

Comment: A commenter requests that the department clarify that an insurer may attest that the insurer's network is adequate even if there are some areas where network requirements are not met due to the absence of providers, if the insurer has provided a local market access plan.

Agency response: The department clarifies that an insurer may take into account waivers and local market access plans when attesting that the insurer's network is adequate for the services to be provided.

Section 3.3722(c)(10)

Comment: A commenter requests that the department revise §3.3722(c)(10) to include a reference to the phrase "if an insured cannot reasonably reach a preferred provider."

Agency response: The department declines to make a change because no change is necessary.

The comment appears to address a prior version of proposed rule text, not the text included in the proposed rule that the department adopts with this order. In the proposed §3.3722(c)(10) the department adopts, the text references §3.3725 generally, which includes reference to situations when insureds cannot reasonably reach preferred providers, so there is no need to include the specific language the commenter requested.

Section 3.3722(d)

Comment: A commenter requests that §3.3722(d) identify the following additional specific items that an insurer must make available during a qualifying examination:

Administrative - policy and procedure manuals; physician and provider manuals; insured materials; organizational charts; and key personnel information, such as resumes and job descriptions.

Complaints - policies and procedures, examples of letters, and examples of complaint logs.

Health information systems - policies and procedures for accessing insureds' health records and a plan to provide for confidentiality of those records in accord with applicable law.

Executed agreements - including management services agreements and administrative services agreements.

Executed preferred provider contracts - a copy of the first page, including the form number, and signature page of individual provider contracts and group provider contracts.

Executed subcontracts - a copy of the first page, including the form number, and signature page of all contracts with subcontracting preferred providers.

Current physician manual and current provider manual which shall be provided to each preferred provider. The manuals must contain details of the requirements by which the preferred providers will be governed.

Credentialing policies and procedures and credentialing files.

Statistical reporting system developed and maintained by the insurer which allows for compiling, developing, evaluating, and reporting statistics relating to the cost of operation, the pattern of utilization of services, and the accessibility and availability of services.

Claims systems - policies and procedures, and systems and processes that demonstrate timely claims payments, and reports that substantiate compliance with all applicable statutes and rules regarding claims payment to physicians, providers, and insureds.

Agency response: The department disagrees with this comment and declines to make a change.

The documents identified by the commenter could be relevant to approving an exclusive provider benefit plan network. However, the department does not agree it is necessary that the rule specifically identify these documents. Under §3.3723, the department may examine the books and records of an insurer when it conducts an examination. It is not necessary or feasible to list every possible document that the department might request during an examination.

Section 3.3722(e)

Comment: A commenter requests that the department revise §3.3722(e) to require an insurer to file with the department prior to implementing network modifications that impact the adequacy of a network:

Forms of any new or amended agreements, contracts, or monitoring plans in the new area, if applicable.

The form of a physician contract and provider contract templates, if applicable.

A description of the method by which the complaint procedure as specified in the subchapter will be made reasonably available in the new service area including a toll free number, and the information and complaint telephone number required by Insurance Code §521.102, where applicable.

Agency response: The department disagrees with the suggestion and declines to make the requested change.

Section 3.3722(e) requires an insurer wishing to make changes to network configuration that impact the adequacy of the network or service area to obtain prior approval of the department.

During that approval process, the department will be able to request any additional documentation it considers necessary. The section already references physician and provider contracts, and it is not necessary to specifically reference agreements with third parties or complaint procedures because the department can request them.

Section 3.3723

Comment: A commenter recommends that the department revise §3.3723 to include the following additional elements as items an insurer must make available during an examination:

Administrative - policy and procedure manuals; physician and provider manuals; insured materials; organizational charts; key personnel information, such as resumes and job descriptions.

Complaints - policies and procedures and templates of letters; complaint files and complaint logs, including documentation and details of actions taken.

Health information systems - policies and procedures for accessing insureds' health records and a plan to provide for confidentiality of those records in accord with applicable law.

Executed agreements, including management services agreements and administrative services agreements.

Credentialing policies and procedures and credentialing files.

Claims systems - policies and procedures, and systems and processes that demonstrate timely claims payments, and reports that substantiate compliance with all applicable statutes and rules regarding claims payment to physicians, providers, and insureds.

Financial records - including statements, ledgers, checkbooks, inventory records, evidence of expenditures, investments, and debts.

Agency response: The documents identified by the commenters could be relevant to an examination of an exclusive provider benefit plan's network. However, the department disagrees with the comment and declines to make the requested change because the department can review the identified documents without the need to list them in the section.

Under §3.3723, the department may examine the books and records of an insurer when it conducts an examination. Further, it is not necessary or feasible to list every possible document that the department might request during an examination.

Section 3.3724(d)

Comment: A commenter supports the requirement under §3.3724(d) that insurers offering exclusive provider benefit plans maintain a strong quality improvement program. The commenter recommends that the department modify §3.3724(d) to emphasize accreditations or certifications specifically tailored to the insurer's quality improvement program. The commenter suggests that the department revise the first sentence of §3.3724(d) to provide that the nonconditional accreditation an insurer receives be "certification specific and germane to the insurer's quality improvement program."

Agency response: The department agrees with the comment and has made the requested change.

Comment: A commenter asks that the department clarify that §3.3724(d) permits the National Committee for Quality Assurance and URAC preferred provider organization accreditation to apply to exclusive provider benefit plans.

Agency response: In response to the comment, the department notes that currently preferred provider organization accreditation under National Committee for Quality Assurance or URAC could be submitted under §3.3724(d) as support for the approval of an insurer's quality improvement program. However, because credentialing programs are subject to change outside of the control of the department, the department will assess each credential presented to it on a case-by-case basis to determine whether the accreditation or certification addresses all material requirements.

This section is intended to provide flexibility for insurers, and the department declines to revise it to specifically reference preferred provider organization or preferred provider benefit plan credentialing by the National Committee for Quality Assurance or URAC.

Section 3.3725

Comment: A commenter says there is no statutory authority for the department to adopt the requirement in §3.3725 that an exclusive provider benefit plan hold an insured harmless when the insured receives care from an out-of-network provider for an emergency or when no network provider is available.

The commenter says this goes beyond language in HB 1772, conflicts with provisions in the Patient Protection and Affordable Care Act, and could have fiscal implications for the state under it. The commenter adds that the Patient Protection and Affordable Care Act defines emergency services, and that the proposed section conflicts with federal regulations that do not require insurers to pay excess amounts.

The commenter says the department should use statutory language related to reimbursement for emergency care and services from nonpreferred providers when no preferred provider is available.

Agency response: The department disagrees with the comment and declines to make a change.

Prior to the bill's passage, the 82nd Legislature amended HB 1772 to include language regarding insurer payment of claims when no preferred provider was available, and provided for payment of claims in cases of emergency that tracks the health maintenance organization statutory language. The legislature was aware that the department has construed the health maintenance organization statutes to require that health maintenance organizations hold enrollees harmless in these situations. See pages 10-12 of the *TDI Biennial Report*

on the department's website at tdi.texas.gov/reports/documents/finalbie07.pdf. As the House Research Organization Report on HB 1772 notes, the amendment requires insurers offering exclusive provider benefit plans to "fully reimburse" out-of-network providers in both of these situations. See the report on the House Research Organization's website at hro.house.state.tx.us/pdf/ba82r/hb1772.pdf#navpanes=0.

Review of the text of Insurance Code §1301.0052 and §1301.0053 reflects a superficial ambiguity as to when insurers are required to pay at a usual and customary rate and when they must pay at a rate agreed to by the provider. The adopted rule resolves the ambiguity consistent with the department's longstanding interpretation of similar language in the health maintenance organization statute.

The department notes that an insured is still responsible for the insured's copayments, deductibles, and coinsurance required under the exclusive provider benefit plan.

Recent federal guidance indicates that states' rules relating to cost-sharing and reimbursement methods are permitted and will not constitute state benefit mandates. See *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Proposed Rule,* available on the Government Printing Office website at gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm.

Comment: A commenter asks that the department confirm that §3.3725 does not apply to out-of-network claims by facility-based physicians in the absence of an emergency situation or a gap in mileage requirements.

Agency response: The department confirms that §3.3725 applies to situations where an insured cannot reasonably reach a preferred provider in cases of emergency or where there is an inadequate provider network. Thus, if an insured were to voluntarily obtain services at an out-of-network facility from out-of-network facility-based physicians, the exclusive provider benefit plan might deny coverage.

The department notes, however, that the situation would be different with an in-network facility. The department is unlikely to approve an insurer's exclusive provider benefit plan network if it includes facilities where the insurer does not have contracted facility-based physicians, due to absence of out-of-network benefits in exclusive provider benefit plans, except as required by Insurance Code Chapter 1301. Further, if an insured receives services at a contracted facility from an out-of-network physician, the department would be likely to view it as falling within §3.3725 if the insured had no choice of physicians.

Comment: A commenter says that the commenter raised concerns during the last legislative session about balance billing of insureds covered by exclusive provider benefit plans. The commenter notes insureds might receive out-of-network care in instances beyond the insured's control. To prevent balance billing the legislature included language in HB 1772 that mirrors language applicable to health maintenance organizations. The commenter says that under the these laws, health maintenance organizations make out-of-network providers whole either by negotiating an agreeable rate with the provider or paying the provider's billed charge. The commenter says that this long-standing practice works fine.

Agency response: The department agrees with the comment that HB 1772 includes language mirroring language applicable to health maintenance organizations.

The department has crafted the rule to protect insureds covered by exclusive provider benefit plans from balance billing in the same way that enrollees in health maintenance organizations are.

Comment: A commenter addresses the framework §3.3725 establishes for insurer payment of out-of-network exclusive provider benefit claims when services are not available from an in-network provider or are emergency services.

The commenter says HB 1772, in addressing insurer reimbursement of nonpreferred providers for medically necessary services not available through a preferred provider and for emergency care, uses language that is taken almost word-for word from the network adequacy requirements of Insurance Code Chapter 1271, which is applicable to health maintenance organizations. Because of this, the commenter says, the department should interpret HB 1772 the same way it does Insurance Code Chapter 1271, holding insurers to the same obligations it applies to health maintenance organizations when their networks fail to make a preferred provider available. The commenter notes that the department has required that health maintenance organizations hold enrollees harmless for necessary out-of-network and emergency care for the past six years. The commenter also points out that under Texas Attorney General Opinion GA-0040, the department cannot prohibit a nonpreferred provider from balance billing an insured.

The commenter says this interpretation is supported by Insurance Code §§1301.0041, 1301.0042, 1301.0052, and 1301.0053. Insurance Code §1301.0041 and §1301.0042 say that, unless otherwise specified, the provisions of Chapter 1301 apply to exclusive provider benefit plans in the same manner they apply to preferred provider benefit plans and that the commissioner may depart from a provision of this Code that "applies to a preferred provider benefit plan" to the extent it is inconsistent with the function of a exclusive provider benefit plan. Insurance Code §1301.0052 and §1301.0053 create distinct obligations for exclusive provider benefit plans which are not applicable to preferred provider benefit plans.

These requirements mirror requirements applicable to health maintenance organizations. Because of this, the commenter says, the department must interpret and apply Insurance Code §1301.0052 and §1301.0053 in the same way as for health maintenance organizations. To achieve this, the commenter says the department must adopt the following text for §3.3725 in place of the text the department proposed:

§3.3725. Settlement of certain claims for services provided by nonpreferred providers. (a) If an insured cannot reasonably reach a preferred provider for the following emergency services the insurer shall fully pay the nonpreferred provider and calculate the insurer's payment and the insured's coinsurance and deductibles for services otherwise available under the plan on the amount submitted on the claim as the nonpreferred provider's billed charge:

(1) a medical screening examination or other examination required by state or federal law to be provided in a hospital emergency facility of a hospital or a freestanding emergency medical care facility, or comparable facility that is necessary to determine whether an emergency medical condition exists;

(2) necessary emergency medical care services, including the treatment and stabilization of an emergency medical condition; and

(3) following treatment or stabilization of an emergency medical condition, services for the medical condition stabilized originating in a hospital emergency facility or freestanding emergency medical care facility, or comparable emergency facility.

(b) If a covered service for medical care, other than emergency care, is medically necessary and not reasonably available through a preferred provider, the insurer shall, in accord with Insurance Code §1301.0052, fully pay the nonpreferred provider and calculate the insurer's payment and the insured's coinsurance and deductibles for services otherwise available under the plan on the amount submitted on the claim as the nonpreferred provider's billed charge.

The commenter says that even if the department does not adopt the first set of alternative text the commenter suggests for §3.3725, the department must still adopt language to insure that an insured receives value for insurance the insured has purchased. The commenter says the following alternative text would be in line with the Texas Attorney General Opinion that the department can only regulate insurers, and not providers, in addressing balance billing:

§3.3725. Settlement of certain claims for services provided by nonpreferred providers. (a) If an insured cannot reasonably reach a preferred provider for the following emergency services, the insurer shall ensure the insured is held harmless and pay the nonpreferred provider an amount sufficient to ensure the provider will not bill the insured, the insured's family, or the insured's guardian for the following emergency services:

(1) a medical screening examination or other examination required by state or federal law to be provided in a hospital emergency facility of a hospital or a freestanding emergency medical care facility, or comparable facility that is necessary to determine whether an emergency medical condition exists;

(2) necessary emergency medical care services, including the treatment and stabilization of an emergency medical condition; and

(3) following treatment or stabilization of an emergency medical condition, services for the medical condition, including complications associated with that condition, stabilized in a hospital emergency facility or freestanding emergency medical care facility, or comparable emergency facility.

(b) If a covered service for medical care, other than emergency care, is medically necessary and not reasonably available through a preferred provider, the insurer shall, in accord with Insurance Code §1301.0052, ensure the insured is held harmless and pay the nonpreferred provider an amount sufficient to ensure the provider will not bill the insured, the insured's family, or the insured's guardian.

Agency response: The department disagrees with the comment and declines to make a change.

The department agrees that the legislature's intent was for insurers offering exclusive provider benefit plans to protect insureds from balance billing. However, no change is necessary because the adopted rule does this while also providing opportunities for insurers to mitigate this requirement's impact on premiums.

Regarding the recommendation that the department require insurers offering exclusive provider benefit plans to base their payments on the billed charge, the department believes that such a requirement is unnecessary in light of its potential impact on premiums. This would also not be consistent with how the department has handled the same situation with health maintenance organizations.

Instead, the adopted rule requires insurers to base their payments on the usual and customary billed charge for the service or a rate agreed to by the provider, tracking the statutory language of §1301.0052 and §1301.0053.

When issuing payment, an insurer must also request that the insured notify the insurer if a balance bill is received. If so, the insurer must ensure that the insured is held harmless for any amounts beyond the copayment, deductible, and coinsurance percentage that the insured would have paid had the insured received services from a preferred provider, thus protecting the insured from balance billed amounts. The rule also permits insurers to exercise some options if they believe the billed charge is excessive, again without harm to the insured.

The department maintains that, given the lack of substantive regulation of the rates charged by providers, the rule strikes a fair balance between the interests of all stakeholders.

The alternative suggestion that the rule require an insurer to pay an amount "sufficient to ensure the provider will not bill the insured," appears to, with only slightly more flexibility, effectively impose a similar requirement that the insurer base its payment on the billed charge, as only such a payment would ensure the provider would not bill the insured. The department believes that the adopted rule more closely tracks the statutory language and intent of the legislature.

Section 3.3725 in general, §3.3725(d) and (e)

Comment: A commenter is pleased with and supports the addition of explicit language generally shielding insureds under exclusive provider benefit plans from balance billing in the cases of emergencies or when an insured is forced to go out-of-network because a network is inadequate to provide medically necessary covered services.

The commenter supports the language in §3.3725(d) and (e) that explicitly addresses the obligation of an exclusive provider benefit plan to generally hold the insured harmless for amounts beyond in-network cost-sharing if an insured cannot reasonably reach a preferred provider or covered services are not available through preferred providers. The commenter says that maintaining this language will provide insureds in exclusive provider benefit plans with the same level of consumer protections as health maintenance organization enrollees in regard to balance billing.

Agency response: The department appreciates the supportive comment.

Section 3.3725(c)

Comment: A commenter says §3.3725(c), which addresses insurer facilitation of an insured's selection of a "non-par" provider when medically necessary covered services, excluding emergency care, are not available through a preferred provider, is confusing and unnecessary.

The commenter asks whether, under §3.3725(c), an insurer could make a suggestion of fewer than three "non-par" providers. The commenter also asks what happens if there are fewer than three "non-par" providers in the service area.

The commenter says the provision creates a disincentive for an insurer to provide any suggestions, as it obligates an insurer to hold an insured harmless if the insured selects a provider from the list of those the insurer suggests.

Agency response: The department disagrees with the comment and declines to make a change.

Section 3.3725(c) does not require an insurer to offer a list of "non-par" providers to an insured. Rather, it allows an insurer to provide a list of nonpreferred providers with whom the insurer has reached an agreement on payment, worked with previously, or otherwise wishes to suggest to the insured.

The rule states that a list an insurer provides cannot include fewer than three providers. If three providers are not available for an insurer to include on a list, the provision of the rule exempting the insurer from holding the insured harmless if they do not select one of the three providers would not be applicable.

The department does not agree that the requirement to hold an insured harmless if the insured selects a provider from the list will create a disincentive for an insurer to provide a list, because under §3.3725(d) - (f) the insurer must still hold the insured harmless if the insurer does not provide a list to facilitate the insured's selection of a nonpreferred provider. On the other hand, an insurer may benefit from making the offer of three providers to an insured. If the insured selects one of the providers, the insurer may be able to reach payment agreements with the provider in advance to limit the insurer's liability, and if the insured does not select one of them, the insurer will not be liable to hold the insured harmless for an unknown dollar amount.

Section 3.3725(c) and (e)

Comment: A commenter is opposed to proposed §3.3725(c), which establishes a process for an insurer to facilitate an insured's selection of a nonpreferred provider when medically necessary covered services, excluding emergency care, are not available through a preferred provider and the insured has received a referral from a preferred provider. The commenter urges the department to not adopt the provision.

The commenter says the subsection allows an insurer to construct an ad hoc network when it has failed to make services from preferred providers reasonably available, noting that the insured must choose from the list of physicians provided or risk losing protections given under the Insurance Code, like being held harmless or receiving coverage for emergency care.

The commenter says that the provision inappropriately rewards insurers that wait to develop an adequate network and enables poor marketplace conduct. The provision fails to offer a solution. Instead it encourages inadequate networks to proliferate. Further, what the department attempts to address with Subsection (c) is already addressed by §3.3705(n), which the department has proposed to delete. Section 3.3705(n) requires insurers to continually monitor their networks, while 3.3725(c) merely gives insurers an additional method to control expenditures at the expense of insureds.

The commenter says that §3.3725(e) suffers from a similar malady and is also objectionable. Under §3.3725(e), if an exclusive provider benefit plan network is inadequate and payment is made, an insured must notify the insurer if the nonpreferred provider bills the insured for amounts beyond the amount paid by the insurer. This provision is presumably designed so that an insurer has information it can use to decide if it should force an insured to mediate a claim.

The commenter says §3.3725(e) suffers from the same problems.

The commenter urges the department to reject adoption of §3.3725 (c) and (e) and adopt alternative language that the commenter offers in regard to all of §3.3725, which is included in a separate comment summary in this preamble.

Agency response: The department disagrees with the comment and declines to make a change.

The rule creates a voluntary option on the part of insurers, while other portions of the rule will limit the frequency of situations where an insured must receive treatment from an out-of-network provider due to network inadequacies. Because of this, it is unlikely that it will be common for insureds covered by exclusive provider benefit plans to be offered a choice of three nonpreferred providers. Regardless, the department believes it important to provide insurers offering exclusive provider benefit plans the opportunity to offer this choice to consumers. A consumer in such a case will be in the same position as if the three providers had been part of the exclusive provider benefit plan network and will be protected against balance billing if one is chosen.

Even if a consumer decides to choose a provider other than the ones suggested by the insurer, the insurer will at least pay part of the claim (an amount at the usual and customary rate), something it would not have done if the insured voluntarily went out of network. An insurer will have the opportunity to arrange one-time payment rates in advance, capping the insurer's potential liability prior to services being rendered, regardless of which choice the insured makes and potentially reducing premium rates for the product.

The department does not believe insurers will regularly rely on the option provided under the rule. In the vast majority of cases it will be more cost effective for insurers to negotiate long-term contracts with individual providers, rather than negotiate one-time contracts with three providers every time a situation arises. Further, insurers will have to annually demonstrate to the department that there are grounds to support a waiver of network adequacy requirements. This may be difficult to do if providers are willing to repeatedly agree to one-time payment arrangements. The department intends to strictly review requests for waivers in those circumstances.

Section 3.3725(c)(3)

Comment: A commenter is concerned by §3.3725(c)(3), which provides for insurer-facilitated selection of a nonpreferred provider by an insured. The commenter says it is fine for an insurer to assist an insured in finding a nonpreferred provider, but the commenter does not support exceptions to hold-harmless provisions for insureds covered by exclusive provider benefit plans.

Agency response: The department disagrees with the comment and declines to make a change.

Section 3.3725 includes a voluntary option for insurers. In addition, other portions of the rule will limit the frequency of situations where an insured must receive treatment from an out-of-network provider due to network inadequacies. Thus, it is unlikely that insurers will frequently offer insureds covered by an exclusive provider benefit plan a choice of three nonpreferred providers.

Regardless, the department believes that it is important to provide insurers offering exclusive provider benefit plans an opportunity to provide this choice to insureds. In these situations, insureds will be in the same position as if the three providers had been the exclusive provider benefit plan's network, and will be protected against balance billing if one is chosen. If the insured

chooses a different provider, the insured may be balance billed, but the insurer will at least pay part of the claim. The insurer will have the opportunity to arrange one-time payment rates in advance, capping the insurer's potential liability prior to services being rendered regardless of which choice the insured makes and potentially reducing premium rates for the product.

Section 3.3725(d)

Comment: A commenter says that §3.3725(d) appears to apply to more than just exclusive provider benefit plans and that it appears to apply in situations not involving exclusive provider plans where an insurer approves service by a non-network provider because no network provider is reasonably available and where an insurer facilitates an insurer's choice of a non-network provider by providing a list of non-network providers to an insured. The commenter says that §3.3725(d) presents a problem in that it requires an insurer to hold an insured harmless in the three situations addressed by the subsection. The commenter says there is no statutory authority for this provision.

The commenter says a hold harmless provision might be appropriate when an insurer has a contract with an exclusive provider but questions how an insurer can achieve this in regard to a provider the insurer has no contract with. The commenter says that the term "hold harmless" is used in specific circumstances in Insurance Code Chapter 843, noting that Insurance Code §843.361 requires a hold harmless provision in a contract between a health maintenance organization and a provider. The commenter says it would also be also consistent with a health maintenance organization that has contracted with a provider under Insurance Code Chapter 843 or a workers' compensation health care network that has contracted with a provider under Insurance Code §1305.152(c). But the commenter concludes that hold harmless requirements are inappropriate in cases where there is no contract with the provider.

The commenter says that while the idea sounds good, it will create a great deal of confusion and liability for insurers and put them at a disadvantage in the marketplace, so the department should not adopt §3.3725(d).

Agency response: The department disagrees with the comment and declines to make a change.

The department notes that the legislature amended the language of HB 1772 to address the payment of claims when no preferred provider was available and in cases of emergency with text that tracks the health maintenance organization statutory language. The legislature was aware that the department has construed the health maintenance organization language to require that health maintenance organizations hold enrollees harmless in these situations. See *Biennial Report of the Texas Department of Insurance to the 80th Texas Legislature* at pages 10-12, tdi.texas.gov/reports/documents/finalbie07.pdf. As the House Research Organization's report on HB 1772 notes, the legislature amended the bill to require that insurers offering exclusive provider benefit plans "fully reimburse" out-of-network providers in both of these situations. See *House Research Organization Bill Analysis for HB 1772* which can be found on the House Research Organization's website at hro.house.state.tx.us/pdf/ba82r/hb1772.pdf#navpanes=0.

The department's intent is to resolve any ambiguity in its interpretation of the statutory text, consistent with legislative intent that insureds be protected when they receive services outside of the exclusive provider benefit plan network through no fault of their own.

Health maintenance organizations have long operated under identical requirements and have been able to hold their enrollees harmless despite the absence of a contract with out-of-network providers. Though the nature of the health maintenance organization contract is different, the issue of payment for out-of-network care is largely the same.

Section 3.3725(d) - (e)

Comment: A commenter says that the different approach for exclusive provider plans in §3.3725(d) - (e) is necessary given the contrasting language of Insurance Code §1301.0053. The commenter says that the hold harmless provision is an obvious consequence of the requirement that plans fully reimburse nonpreferred emergency care providers at the usual and customary rate or at an agreed rate. Because of these requirements, the commenter says, the annual out-of-pocket maximum clarification at §3.3708(b) is unnecessary in §3.3725, as the insureds of exclusive provider benefits plans will be held harmless by the plans on the balance bills contemplated in both proposed sections.

Agency response: The department agrees that an insured covered by an exclusive provider benefit plan should only be responsible for the insured's coinsurance, deductible, and copayment when treated by an out-of-network provider because of an emergency or an inadequate network. However, the department does not believe a change to the rule text is necessary. The insured will receive credit for these amounts toward the insured's out of pocket maximum under the plan.

Because the insured is not required to pay any balance bill, there is no need for the department to implement a requirement that insurers credit insureds for out-of-pocket expenses similar to the requirement in §3.3708(b) in the context of an exclusive provider benefit plan.

Section 3.3725(e)

Comment: A commenter says that §3.3725(e) creates a requirement for exclusive provider benefit plans to reimburse all out-of-network providers at the usual and customary rate. The commenter says this provision conflicts with law and should be deleted.

Agency response: The department disagrees with the comment and declines to make a change.

The reference in §3.3725(e) to "usual and customary" tracks the statutory requirements in Insurance Code §1301.0052 and §1301.0053 that out-of-network providers be reimbursed at the "usual and customary rate" or an agreed rate. The rule does not create a requirement that all out-of-network providers be paid at the usual and customary rate, but only for those in the narrow circumstances stated in the rule. Review of the text of Insurance Code §1301.0052 and §1301.0053 reflects a superficial ambiguity as to when insurers are required to pay at a usual and customary rate and when they must pay at a rate agreed to by the provider. The adopted rule resolves the ambiguity consistent with the department's longstanding interpretation of similar language in the health maintenance organization statute.

Comment: A commenter opposes §3.3725(e), which the commenter says permits an insurer to contractually require insureds under exclusive provider benefit plans to mediate claims that are eligible for mediation under Insurance Code Chapter 1467 and related rules. The commenter says §3.3725(e)(2) allows insurers to force consumers to mediate. A second commenter says that §3.3725(e) is confusing. The second commenter also says there is no statutory authority for the provision and that the re-

quirement goes far beyond the language of the statute. A third commenter says the provision conflicts with statutes and other rules, but the commenter does not specify the statute or rules that the provision conflicts with.

The first commenter says that when an insured receives care from an out-of-network provider, there is no privity of contract between the insurer and the provider. The commenter also says that Insurance Code Chapter 1467 solely gives an insured the choice to mediate, and the commenter says that the idea an insurer could force an insured to mediate is contrary to the legislature's intent.

The first commenter says §3.3725(e)(2) introduces unnecessary complications to a process that is already applicable to exclusive provider benefit plans under statute. The legislature developed the mediation process in Insurance Code Chapter 1467 to give insureds an option to request mediation, but the proposed rules give the insured's decision-making power to the insurer by threatening a penalty of the loss of the hold-harmless benefit.

The first commenter says this was not the intent of the legislature, because under HB 1722 insurers offering exclusive provider benefit plans must comply with all laws applicable to preferred provider benefit plans, including Insurance Code Chapter 1467, unless the commissioner determines a law applicable to a preferred provider benefit plan is inconsistent with the function or purpose of an exclusive provider benefit plan. The first commenter does not think it necessary to depart from laws applicable to preferred provider plans in regard to mediation under Insurance Code Chapter 1467 and says that the rule proposal does not provide an explanation for the non-alignment in the rule proposal.

The first commenter also asks why the department is now embracing a mandatory mediation process it rejected in May of 2011. The commenter references a comment in the May 19, 2011, adoption order in which a commenter asked the department to establish an alternative dispute resolution process to resolve billing disputes similar to a process established in Illinois in 2011. In response to the comment, the department said that it did not have authority to establish the requested process.

The first commenter also expresses concerns that insurers will rely on §3.3725(e) to draft contract provisions that rescind coverage when an insured does not pursue mediation. The commenter adds that the provision addresses this concern by threatening consumers with the loss of hold-harmless protections and asserts that the whole purpose of the proposed mandatory mediation framework is to ensure that insurers can mitigate their expenses when they fail to provide networks they have promised to insureds.

The first commenter concludes by asserting that §3.3725(e)(2)(A)(ii) and (iii) indicates intent to give insurers permission to penalize consumers for the benefit of insurers. The commenter says that §3.3725(e)(2)(A)(ii) says insurers cannot penalize insureds, but the commenter adds that §3.3725(e)(2)(A)(iii) creates a clear exception so that insurers can penalize insureds until they bend to the insurer's will. There is no recourse for insureds and no penalty on insurers who "demand mandatory mediation in bad faith." The concept that an insurer can escape promises made to an insured to cover losses due to medical expenses through the proposed regulatory scheme is poor public policy.

The first commenter asks that the department not adopt §3.3725(e) or any other provision that would allow an insurer to trigger mediation, that the department revise the figure in §3.3705(f)(2) to remove any mention that an insurer can force mediation, and that it drop the concept of forced mediation. As an alternative, the first commenter says that if the department does adopt provisions providing for mediation, it should give insureds the right to settle a claim with a nonpreferred provider at any amount and make this settlement binding on the insurer.

Agency response: The department does not agree with the comments and declines to make a change.

It is important to recognize that the mediation issue will occur very rarely under the proposed rules. First, the new network adequacy requirements will ensure that exclusive provider benefit plans have adequate networks, so insureds will seldom be required to receive out-of-network care. The rule also requires exclusive provider benefit plans to make an initial payment in these circumstances at the usual and customary billed charge for the services or an agreed rate.

The only time mediation is available under Insurance Code Chapter 1467 is when a facility-based physician's balance bill exceeds $1,000. The department believes that it will be very rare that a facility-based physician will balance bill an insured beyond the usual and customary charge. The department notes that Insurance Code Chapter 1467 became effective in 2009, yet the department has not referred a single case for formal mediation since that time.

Section 3.3725(e) does not allow an insurer to force an insured to mediate a claim. To the contrary, the text of §3.3725(e)(2)(A)(i) expressly provides that an insurer may not require that an insured participate in mediation. This is consistent with Insurance Code §1467.054, which says participation in mediation by an insured is elective.

Section 3.3725(e) is not a departure from the requirements of Insurance Code Chapter 1467 or other laws that apply to preferred and exclusive provider benefit plans. Nothing in Insurance Code Chapter 1467 prohibits insurers from including language in insurance policies requiring the initiation of mediation. Through the rule, the department is regulating the use of such requirements by insurers and limiting the consequences that may be imposed under the policy for the refusal to initiate mediation.

It is important to recognize that requiring the insurer to pay the billed charge also imposes a burden on the insured to pay their coinsurance percentage of a facility-based physician's billed charge, an amount that may exceed $1,000 and that is not eligible for mediation under Insurance Code Chapter 1467. By creating a process for the insurer and the physician to mediate a charge, the consumer may substantially benefit if the coinsurance percentage is calculated on a smaller amount than the billed charge.

The department believes that the rule best effectuates the intent of the legislature in requiring that insurers pay the usual and customary rate or a "rate agreed to by the issuer and the nonpreferred provider."

Given that an insured is only required to initiate the mediation process, not participate in it, and that the result of the mediation process can only decrease the insured's out-of-pocket costs, not increase them, the department does not believe the rule creates an unreasonable burden on insureds.

Section 3.3725(e) is not contrary to the department's previous position addressed in the May 19, 2011, adoption order. The pro-

vision only addresses mediation under Insurance Code Chapter 1467 and related rules, and it does not establish alternative or

Section 3.3725(e) does not apply Insurance Code Chapter 1467 differently to preferred or exclusive provider benefit plans. If an insured requests mediation under Insurance Code Chapter 1467, an insurer would follow the same procedure regardless of whether the claim resulted from care delivered through a preferred or an exclusive provider benefit plan. Chapter 1467 does not address whether insurers may create incentives for requesting mediation.

Further, the department has not embraced the mandatory dispute resolution process it rejected in response to a comment in the May 19, 2011, adoption order. Under the Illinois law, certain billing disputes that an insurer and provider cannot settle through negotiation are resolved through binding arbitration. In response to the comment, the department noted that it lacked statutory authority to establish an alternative dispute process for mandatory claim settlement, except to the extent that Insurance Code Chapter 1467 already applies to the claim.

As pointed out in the comment, in situations where an insured receives care from a non-network provider, the department has no authority to limit what the non-network provider bills the insured. Insureds receiving out-of-network or emergency care generally have limited ability to negotiate with providers on what they will bill. The commenter also notes that in out-of-network care situations there is no privity of contract between the provider and the insurer, so the insurer has no say in regard to what the provider bills. So, in out-of-network situations the provider has all the power over billed charges.

Insurance Code Chapter 1467 provides options to address, to a limited extent, this unlevel playing field. In the situations it applies to, an insured that a provider has balance billed can request mediation, and the insurer and provider must come to the table in good faith to attempt to resolve the claim. However, because mediation under Insurance Code Chapter 1467 must be requested by the insured, the insurer has limited ability to initiate the process. Section 3.3725(e) opens an avenue for an insurer into the mediation process by allowing the insurer's contract with an insured to require that an insured request mediation under Insurance Code Chapter 1467 and related rules when it is available.

To ensure that the burden on an insured is not too high, the department clarified in the rule proposal that even though an insurer is permitted to require an insured to request mediation, the insurer must inform the insured when mediation is available and may not penalize an insured for failing to request or failing to participate in mediation beyond delaying final adjudication of the claim until the insured requests. Under Insurance Code Chapter 1467, an insured is not subject to administrative penalties for failing to participate in mediation. Once the mediation is requested, an insured no longer needs to participate. At that point, it can become a process between the insurer and the non-network provider.

The department does not agree that an insurer faces no penalty for demanding "mandatory mediation in bad faith." Insurance Code Chapter 1467 and related rules provide for administrative action by the department when an insurer acts in bad faith in a mediation. Insurance Code Chapter 542 prohibits unfair claim settlement practices, such as failing to attempt in good faith to effect a prompt, fair, and equitable settlement of a claim.

Further, given the administrative costs for an insurer to participate in mediation, the department does not believe insurers will pursue mediation in bad faith. An insurer will have already paid the claim at the usual and customary billed rate for the service, and it is difficult to imagine circumstances where it would constitute bad faith to dispute a charge above the usual and customary rate.

The department does not believe it is necessary for the department to permit an insured to bind an insurer to a settlement amount. Both the insurer and the insured will have an aligned financial interest in reducing the billed charge as much as possible, because the insured remains liable for their coinsurance portion of the final charge. If the insured voluntarily participates in the mediation, then the mediator will work with all parties toward an agreeable resolution. If the insured does not participate, the department does not believe it is necessary to give the insured final say in the settlement amount reached through the mediation process.

Section 3.3725(e)(2)

Comment: A commenter references previous concerns the commenter had that an insurer might contractually require a consumer to participate in mediation under §3.3725(e)(2). The commenter says that the provisions proposed by the department in §3.3725(e)(2)(A)(i) - (iii) address the commenter's concerns and provide reasonable protections for consumers and insurers. The commenter says §3.3725(e)(2) will benefit consumers by providing a mechanism for providers and insurers to negotiate bills.

Agency response: The department appreciates the supportive comment and agrees with the commenter's conclusion that §3.3725(e)(2) will benefit consumers by providing a mechanism for providers and insurers to negotiate bills.

Section 3.3725(f)

Comment: A commenter says that §3.3725(f) appears to regulate how insurers determine usual and customary rates. The commenter contends there is no statutory authority for the department to legislate this by rule.

A second commenter also makes this point and requests that the department delete §3.3725(f) on the grounds that the department lacks statutory authority to establish standards for reimbursement methodology.

Agency response: The department disagrees with the comment and declines to make a change.

Section 3.3725(f) applies basic standards of fairness to reimbursements based on usual and customary charges, requiring insurers to use generally accepted industry standards for determining usual and customary billed charges. An insurer may base its reimbursements on claims data; but if it does so, it must use data that is updated periodically. Further, an insurer must use generally accepted bundling edits and logic when determining how to pay its claims. An insurer that fails to comply with these fundamental requirements would be selling a product that is unjust, encourages misrepresentation, or is deceptive under Insurance Code Chapter 1701. If insurers do not comply with these requirements, insureds will not be able to have any confidence that their claims are paid correctly or fairly.

Insurance Code §1301.007 requires the commissioner to adopt rules as necessary to implement Insurance Code Chapter 1301. Failure to address the methodology insurers use to calculate out-of-network reimbursement could adversely affect insureds

and providers, particularly if insurers use old data, statistically insignificant samples, or any other information described by §3.3725(f) to calculate out-of-network reimbursements.

NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For with changes: Coalition for Nurses in Advanced Practice, Texas Association of Health Plans, Texas College of Emergency Physicians, Aetna Insurance Company, Center for Public Policy Priorities, Texas Emergency Medicine Practice Alliance, Texas Association of Life and Health Insurers, Texas Association of Health Plans, and Emergency Service Partners.

Against: Texas Association of Business and Texas Medical Association.

DIVISION 1. GENERAL REQUIREMENTS

28 TAC §§3.3701 - 3.3710

STATUTORY AUTHORITY. The department adopts the amendments and new sections under Insurance Code §§1301.003, 1301.0042, 1301.007, 1301.005, 1301.006, 1301.0051, 1301.0052, 1301.0053, 1301.0055,1301.0056, 1301.1581, 1701.055, 1201.006, 1201.101, 1201.102, 1251.008, 1456.006, 1456.003, 1501.010, and 36.001.

Insurance Code §1301.003 provides that an exclusive provider benefit plan that meets the requirements of Chapter 1301, relating to Preferred Provider Benefit Plans, is not unjust under Insurance Code Chapter 1701; unfair discrimination under Insurance Code Chapter 55, Subchapter A or B; or a violation of Insurance Code, Chapter 1451, Subchapter B or C.

Insurance Code §1301.0042 provides that, except for dental care benefits, a provision of the Insurance Code or other insurance law that applies to a preferred provider benefit plan also applies to an exclusive provider benefit plan, except to the extent that the commissioner determines the provision is inconsistent with the function and purpose of an exclusive provider benefit plan. Insurance Code §1301.0042 also authorizes the commissioner to determine whether a provision is inconsistent with the function and purpose of an exclusive provider benefit plan.

Insurance Code §1301.007 authorizes the commissioner to adopt rules to implement Insurance Code Chapter 1301, relating to Preferred Provider Benefit Plans, and to ensure reasonable accessibility and availability of preferred provider services to residents of this state.

Insurance Code §1301.005 provides that an insurer must reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider if services are not available through a preferred provider within a designated service area under a preferred provider benefit plan.

Insurance Code §1301.006 requires that an insurer that markets a preferred provider benefit plan contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities.

Insurance Code §1301.0051 provides that an insurer that offers an exclusive provider benefit plan must establish procedures to ensure that health care services are provided to insureds under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of care or practice.

Insurance Code §1301.0052 provides that if a covered service is medically necessary and is not available through a preferred provider, the issuer of an exclusive provider benefit plan, on the request of a preferred provider must approve the referral of an insured to a nonpreferred provider within a reasonable period and fully reimburse the nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider. Insurance Code §1301.0052 also requires an exclusive provider benefit plan to provide for a review by a health care provider with expertise in the same specialty as or a specialty similar to the type of health care provider to whom a referral is requested before the issuer of the plan may deny the referral.

Insurance Code §1301.0053 provides that if a nonpreferred provider provides emergency care as defined by Insurance Code §1301.155 to an insured in an exclusive provider benefit plan, the issuer of the plan must reimburse the nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider for the provision of the services.

Insurance Code §1301.0055 requires the commissioner to adopt by rule network adequacy standards that: (i) are adapted to local markets where an insurer offers a preferred provider benefit plan; (ii) ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health services to insureds; and (iii) on good cause shown, may allow departure from local market network adequacy standards if the commissioner posts on the department's website the name of the preferred provider plan, the insurer offering the plan, and the affected local market.

Insurance Code §1301.0056 authorizes the commissioner to examine an insurer to determine the quality and adequacy of a network used by an exclusive provider benefit plan offered by the insurer under this chapter and requires an insurer examined under the section to pay the cost of the examination in an amount determined by the commissioner.

Insurance Code §1301.1581 requires an insurer that offers an exclusive provider benefit plan to provide to a current or prospective group contract holder or current or prospective insured notice that the benefit plan includes limited coverage for services provided by a physician or health care provider that is not a preferred provider.

Insurance Code §1701.055(a)(2) authorizes the commissioner to disapprove or, after notice and hearing, withdraw approval of a form if the form contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive, subject to the exception specified in subsection (d) of the section.

Insurance Code §1201.006 authorizes the commissioner to adopt reasonable rules as necessary to implement Insurance Code Chapter 1201.

Insurance Code §1201.101 and §1201.102 authorize the commissioner to adopt rules specifying the content of an individual accident and health insurance policy and to prohibit provisions in individual accident and health insurance policies that the com-

missioner determines to be unjust, unfair, or unfairly discriminatory.

Insurance Code §1251.008 authorizes the commissioner to adopt rules necessary to administer the group health insurance chapter of the Insurance Code.

Insurance Code §1456.006 authorizes the commissioner to adopt by rule specific requirements for the health benefit plan disclosure required under §1456.003.

Insurance Code §1501.010 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1501, the Health Insurance Portability and Availability Act.

Insurance Code §36.001 provides that the commissioner of insurance may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

§3.3702. Definitions.

(a) Words and terms defined in Insurance Code Chapter 1301 have the same meaning when used in this subchapter, unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Adverse determination--As defined in Insurance Code §4201.002(1).

(2) Allowed amount--The amount of a billed charge that an insurer determines to be covered for services provided by a nonpreferred provider. The allowed amount includes both the insurer's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(3) Billed charges--The charges for medical care or health care services included on a claim submitted by a physician or provider.

(4) Complainant--As defined in §21.2502 of this title (relating to Definitions).

(5) Complaint--As defined in §21.2502 of this title.

(6) Contract holder--An individual who holds an individual health insurance policy, or an organization that holds a group health insurance policy.

(7) Exclusive provider network--The collective group of physicians and health care providers available to an insured under an exclusive provider benefit plan and directly or indirectly contracted with the insurer of an exclusive provider benefit plan to provide medical or health care services to individuals insured under the plan.

(8) Facility--

(A) an ambulatory surgical center licensed under Health and Safety Code Chapter 243;

(B) a birthing center licensed under Health and Safety Code Chapter 244; or

(C) a hospital licensed under Health and Safety Code Chapter 241.

(9) Facility-based physician--A radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist:

(A) to whom a facility has granted clinical privileges; and

(B) who provides services to patients of the facility under those clinical privileges.

(10) Health care provider or provider--As defined in Insurance Code §1301.001(1-a).

(11) Health maintenance organization (HMO)--As defined in Insurance Code §843.002(14).

(12) In-network--Medical or health care treatment, services, or supplies furnished by a preferred provider, or a claim filed by a preferred provider for the treatment, services, or supplies.

(13) NCQA--The National Committee for Quality Assurance, which reviews and accredits managed care plans.

(14) Nonpreferred provider--A physician or health care provider, or an organization of physicians or health care providers, that does not have a contract with the insurer to provide medical care or health care on a preferred benefit basis to insureds covered by a health insurance policy issued by the insurer.

(15) Out-of-network--Medical or health care treatment services, or supplies furnished by a nonpreferred provider, or a claim filed by a nonpreferred provider for the treatment, services, or supplies.

(16) Pediatric practitioner--A physician or provider with appropriate education, training, and experience whose practice is limited to providing medical and health care services to children and young adults.

(17) Rural area--

(A) a county with a population of 50,000 or less as determined by the United States Census Bureau in the most recent decennial census report;

(B) an area that is not designated as an urbanized area by the United States Census Bureau in the most recent decennial census report; or

(C) any other area designated as rural under rules adopted by the commissioner, notwithstanding subparagraphs (A) and (B) of this paragraph.

(18) Urgent care--Medical or health care services provided in a situation other than an emergency that are typically provided in a setting such as a physician or individual provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, illness, or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of the person's health.

(19) Utilization review--As defined in Insurance Code §4201.002(13).

§3.3703. Contracting Requirements.

(a) An insurer marketing a preferred provider benefit plan must contract with physicians and health care providers to assure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the plan in a manner that assures both availability and accessibility of adequate personnel, specialty care, and facilities. Each contract must meet the following requirements:

(1) A contract between a preferred provider and an insurer may not restrict a physician or health care provider from contracting with other insurers, preferred provider plans, preferred provider networks or organizations, exclusive provider benefit plans, exclusive

provider networks or organizations, health care collaboratives, or HMOs.

(2) Any term or condition limiting participation on the basis of quality that is contained in a contract between a preferred provider and an insurer is required to be consistent with established standards of care for the profession.

(3) In the case of physicians or practitioners with hospital or institutional provider privileges who provide a significant portion of care in a hospital or institutional provider setting, a contract between a preferred provider and an insurer may contain terms and conditions that include the possession of practice privileges at preferred hospitals or institutions, except that if no preferred hospital or institution offers privileges to members of a class of physicians or practitioners, the contract may not provide that the lack of hospital or institutional provider privileges may be a basis for denial of participation as a preferred provider to such physicians or practitioners of that class.

(4) A contract between an insurer and a hospital or institutional provider shall not, as a condition of staff membership or privileges, require a physician or practitioner to enter into a preferred provider contract. This prohibition does not apply to requirements concerning practice conditions other than conditions of membership or privileges.

(5) A contract between a preferred provider and an insurer may provide that the preferred provider will not bill the insured for unnecessary care, if a physician or practitioner panel has determined the care was unnecessary, but the contract may not require the preferred provider to pay hospital, institutional, laboratory, x-ray, or like charges resulting from the provision of services lawfully ordered by a physician or health care provider, even though such service may be determined to be unnecessary.

(6) A contract between a preferred provider and an insurer may not:

(A) contain restrictions on the classes of physicians and practitioners who may refer an insured to another physician or practitioner; or

(B) require a referring physician or practitioner to bear the expenses of a referral for specialty care in or out of the preferred provider panel. Savings from cost-effective utilization of health services by contracting physicians or health care providers may be shared with physicians or health care providers in the aggregate.

(7) A contract between a preferred provider and an insurer may not contain any financial incentives to a physician or a health care provider which act directly or indirectly as an inducement to limit medically necessary services. This subsection does not prohibit the savings from cost-effective utilization of health services by contracting physicians or health care providers from being shared with physicians or health care providers in the aggregate.

(8) An insurer's contract with a physician, physician group, or practitioner must have a mechanism for the resolution of complaints initiated by an insured, a physician, physician group, or practitioner. The mechanism must provide for reasonable due process including, in an advisory role only, a review panel selected as specified in §3.3706(b)(2) of this title (relating to Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process).

(9) A contract between a preferred provider and an insurer may not require any health care provider, physician, or physician group to execute hold harmless clauses that shift an insurer's tort liability resulting from acts or omissions of the insurer to the preferred provider.

(10) A contract between a preferred provider and an insurer must require a preferred provider who is compensated by the insurer on a discounted fee basis to agree to bill the insured only on the discounted fee and not the full charge.

(11) A contract between a preferred provider and an insurer must require the insurer to comply with all applicable statutes and rules pertaining to prompt payment of clean claims with respect to payment to the provider for covered services rendered to insureds.

(12) A contract between a preferred provider and an insurer must require the provider to comply with the Insurance Code §§1301.152 - 1301.154, which relates to Continuity of Care.

(13) A contract between a preferred provider and an insurer may not prohibit, penalize, permit retaliation against, or terminate the provider for communicating with any individual listed in the Insurance Code §1301.067 about any of the matters set forth therein.

(14) A contract between a preferred provider and an insurer conducting, using, or relying upon economic profiling to terminate physicians or health care providers from a plan must require the insurer to inform the provider of the insurer's obligation to comply with the Insurance Code §1301.058.

(15) A contract between a preferred provider and an insurer that engages in quality assessment is required to disclose in the contract all requirements of the Insurance Code §1301.059(b).

(16) A contract between a preferred provider and an insurer may not require a physician to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an insured by a pharmacist.

(17) A contract between a preferred provider and an insurer may not prohibit a pharmacist from administering immunizations or vaccinations if such immunizations or vaccinations are administered in accordance with the Texas Pharmacy Act, Chapters 551 - 566 and Chapters 568 - 569 of the Occupations Code, and rules promulgated thereunder.

(18) A contract between a preferred provider and an insurer must require a provider that voluntarily terminates the contract to provide reasonable notice to the insured, and must require the insurer to provide assistance to the provider as set forth in the Insurance Code §1301.160(b).

(19) A contract between a preferred provider and an insurer must require written notice to the provider on termination of the contract by the insurer, and in the case of termination of a contract between an insurer and a physician or practitioner, the notice must include the provider's right to request a review, as specified in §3.3706(d) of this title.

(20) A contract between a preferred provider and an insurer must include provisions that will entitle the preferred provider upon request to all information necessary to determine that the preferred provider is being compensated in accordance with the contract. A preferred provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds. The insurer may provide the required information by any reasonable method through which the preferred provider can access the information, including e-mail, computer disks, paper, or access to an electronic database. Amendments, revisions, or substitutions of any information provided pursuant to this paragraph are required to be made in accordance with subparagraph

(D) of this paragraph. The insurer is required to provide the fee schedules and other required information by the 30th day after the date the insurer receives the preferred provider's request.

(A) This information is required to include a preferred provider specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by the preferred provider. At a minimum, the information is required to include:

(i) a fee schedule, including, if applicable, CPT, HCPCS, ICD-9-CM codes or successor codes, and modifiers:

(I) by which all claims for covered services submitted by or on behalf of the preferred provider will be calculated and paid; or

(II) that pertains to the range of health care services reasonably expected to be delivered under the contract by that preferred provider on a routine basis along with a toll-free number or electronic address through which the preferred provider may request the fee schedules applicable to any covered services that the preferred provider intends to provide to an insured and any other information required by this paragraph that pertains to the service for which the fee schedule is being requested if that information has not previously been provided to the preferred provider;

(ii) all applicable coding methodologies;

(iii) all applicable bundling processes, which are required to be consistent with nationally recognized and generally accepted bundling edits and logic;

(iv) all applicable downcoding policies;

(v) a description of any other applicable policy or procedure the insurer may use that affects the payment of specific claims submitted by or on behalf of the preferred provider, including recoupment;

(vi) any addenda, schedules, exhibits, or policies used by the insurer in carrying out the payment of claims submitted by or on behalf of the preferred provider that are necessary to provide a reasonable understanding of the information provided pursuant to this paragraph; and

(vii) the publisher, product name, and version of any software the insurer uses to determine bundling and unbundling of claims.

(B) In the case of a reference to source information as the basis for fee computation that is outside the control of the insurer, such as state Medicaid or federal Medicare fee schedules, the information provided by the insurer is required to clearly identify the source and explain the procedure by which the preferred provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

(C) Nothing in this paragraph may be construed to require an insurer to provide specific information that would violate any applicable copyright law or licensing agreement. However, the insurer is required to supply, in lieu of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds as required by subparagraph (A) of this paragraph.

(D) No amendment, revision, or substitution of claims payment procedures or any of the information required to be provided by this paragraph will be effective as to the preferred provider, unless the insurer provides at least 90 calendar days written notice to the preferred provider identifying with specificity the amendment, revision or substitution. An insurer may not make retroactive changes to claims payment procedures or any of the information required to be provided by this paragraph. Where a contract specifies mutual agreement of the parties as the sole mechanism for requiring amendment, revision or substitution of the information required by this paragraph, the written notice specified in this section does not supersede the requirement for mutual agreement.

(E) Failure to comply with this paragraph constitutes a violation as set forth in subsection (b) of this section.

(F) This paragraph applies to all contracts entered into or renewed on or after the effective date of this paragraph. Upon receipt of a request, the insurer is required to provide the information required by subparagraphs (A) - (D) of this paragraph to the preferred provider by the 30th day after the date the insurer receives the preferred provider's request.

(G) A preferred provider that receives information under this paragraph:

(i) may not use or disclose the information for any purpose other than:

(I) the preferred provider's practice management;

(II) billing activities;

(III) other business operations; or

(IV) communications with a governmental agency involved in the regulation of health care or insurance;

(ii) may not use this information to knowingly submit a claim for payment that does not accurately represent the level, type or amount of services that were actually provided to an insured or to misrepresent any aspect of the services; and

(iii) may not rely upon information provided pursuant to this paragraph about a service as a representation that an insured is covered for that service under the terms of the insured's policy or certificate.

(H) A preferred provider that receives information under this paragraph may terminate the contract on or before the 30th day after the date the preferred provider receives information requested under this paragraph without penalty or discrimination in participation in other health care products or plans. If a preferred provider chooses to terminate the contract, the insurer is required to assist the preferred provider in providing the notice required by paragraph (18) of this subsection.

(I) The provisions of this paragraph may not be waived, voided, or nullified by contract.

(21) An insurer may require a preferred provider to retain in the preferred provider's records updated information concerning a patient's other health benefit plan coverage.

(22) Upon request by a preferred provider, an insurer is required to include a provision in the preferred provider's contract providing that the insurer and the insurer's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this section, the term batch submission is a group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identi-

fied by a batch control number. This paragraph applies to a contract entered into or renewed on or after January 1, 2006.

(23) A contract between an insurer and a preferred provider other than an institutional provider may contain a provision requiring a referring physician or provider, or a designee, to disclose to the insured:

(A) that the physician, provider, or facility to whom the insured is being referred might not be a preferred provider; and

(B) if applicable, that the referring physician or provider has an ownership interest in the facility to which the insured is being referred.

(24) A contract provision that requires notice as specified in paragraph (23)(A) of this subsection is required to allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care and may not limit access to nonpreferred providers.

(25) A contract between an insurer and a preferred provider must require the preferred provider to comply with all applicable requirements of the Insurance Code §1661.005 (relating to refunds of overpayments from enrollees).

(26) A contract between an insurer and a facility must require that the facility give notice to the insurer of the termination of a contract between the facility and a facility-based physician group that is a preferred provider for the insurer as soon as reasonably practicable, but not later than the fifth business day following termination of the contract.

(27) A contract between an insurer and a preferred provider must require, except for instances of emergency care as defined under Insurance Code §1301.155(a), that a physician or provider referring an insured to a facility for surgery:

(A) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information;

(B) notify the insurer that surgery has been recommended; and

(C) notify the insurer of the facility that has been recommended for the surgery.

(28) A contract between an insurer and a facility must require, except for instances of emergency care as defined under Insurance Code §1301.155(a), that the facility, when scheduling surgery:

(A) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information; and

(B) notify the insurer that surgery has been scheduled.

(b) In addition to all other contract rights, violations of these rules will be treated for purposes of complaint and action in accordance with Insurance Code Chapter 542, Subchapter A, and the provisions of that subchapter will be utilized insofar as practicable, as it relates to the power of the department, hearings, orders, enforcement, and penalties.

(c) An insurer may enter into an agreement with a preferred provider organization, an exclusive provider network, or a health care collaborative for the purpose of offering a network of preferred providers, provided that it remains the insurer's responsibility to:

(1) meet the requirements of Insurance Code Chapter 1301 and this subchapter;

(2) ensure that the requirements of Insurance Code Chapter 1301 and this subchapter are met; and

(3) provide all documentation to demonstrate compliance with all applicable rules on request by the department.

§3.3704. Freedom of Choice; Availability of Preferred Providers.

(a) Fairness requirements. A preferred provider benefit plan is not considered unjust under Insurance Code §§1701.002 - 1701.005; 1701.051 - 1701.060; 1701.101 - 1701.103; and 1701.151, or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, or §§544.051 - 544.054, or to violate §§1451.001, 1451.053, 1451.054, or 1451.101 - 1451.127 of the Insurance Code provided that:

(1) pursuant to Insurance Code §§1251.005, 1251.006, 1301.003, 1301.006, 1301.051, 1301.053, 1301.054, 1301.055, 1301.057 - 1301.062, 1301.064, 1301.065, 1301.151, 1301.156, and 1301.201, the preferred provider benefit plan does not require that a service be rendered by a particular hospital, physician, or practitioner;

(2) insureds are provided with direct and reasonable access to all classes of physicians and practitioners licensed to treat illnesses or injuries and to provide services covered by the preferred provider benefit plan;

(3) insureds have the right to treatment and diagnostic techniques as prescribed by a physician or other health care provider included in the preferred provider benefit plan;

(4) insureds have the right to continuity of care as set forth in the Insurance Code §§1301.152 - 1301.154;

(5) insureds have the right to emergency care services as set forth in Insurance Code §1301.0053 and §1301.155, and §3.3708 of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures) and §3.3725 of this title (relating to Payment of Certain Out-of-Network Claims);

(6) the basic level of coverage, excluding a reasonable difference in deductibles, is not more than 50 percent less than the higher level of coverage, except as provided under an exclusive provider benefit plan. A reasonable difference in deductibles is determined considering the benefits of each individual policy;

(7) the rights of an insured to exercise full freedom of choice in the selection of a physician or provider, or in the selection of a preferred provider under an exclusive provider benefit plan, are not restricted by the insurer;

(8) if the insurer is issuing other health insurance policies in the service area that do not provide for the use of preferred providers, the basic level of coverage of a plan that is not an exclusive provider benefit plan is reasonably consistent with other health insurance policies offered by the insurer that do not provide for a different level of coverage for use of a preferred provider;

(9) any actions taken by an insurer engaged in utilization review under a preferred provider benefit plan is taken pursuant to the Insurance Code Chapter 4201 and Chapter 19, Subchapter R of this title (relating to Utilization Review Agents);

(10) a preferred provider benefit plan that is not an exclusive provider benefit plan may provide for a different level of coverage for use of a nonpreferred provider if the referral is made by a preferred provider only if full disclosure of the difference is included in the plan and the written description as required by §3.3705(b) of this title (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations);

(11) both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area; and

(12) if medically necessary covered services are not reasonably available through preferred physicians or providers, insureds have the right to receive care from a nonpreferred provider in accord with Insurance Code §1301.005 and §1301.0052, and §3.3708 and §3.3725 of this title, as applicable.

(b) Notwithstanding subsection (a)(11) of this section, an exclusive provider benefit plan is not considered unjust under Insurance Code §§1701.002 - 1701.005, 1701.051 - 1701.060, 1701.101 - 1701.103, and 1701.151; or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, or §§544.051 - 544.054, or to violate Insurance Code §§1451.101 - 1451.127, provided that:

(1) the exclusive provider benefit plan complies with subsection (a)(1) - (10) and (12) of this section; and

(2) for the purposes of subsection (a)(11) of this section, an exclusive provider benefit plan must only ensure that preferred provider benefits are reasonably available to all insureds within a designated service area.

(c) Payment of nonpreferred providers. Payment by the insurer must be made for covered services of a nonpreferred provider in the same prompt and efficient manner as to a preferred provider.

(d) Retaliatory action prohibited. An insurer is prohibited from engaging in retaliatory action against an insured, including cancellation of or refusal to renew a policy, because the insured or a person acting on behalf of the insured has filed a complaint with the department or the insurer against the insurer or a preferred provider or has appealed a decision of the insurer.

(e) Access to certain institutional providers. In addition to the requirements for availability of preferred providers set forth in Insurance Code §1301.005, any insurer offering a preferred provider benefit plan must make a good faith effort to have a mix of for-profit, non-profit, and tax-supported institutional providers under contract as preferred providers in the service area to afford all insureds under the plan freedom of choice in the selection of institutional providers at which they will receive care, unless the mix is not feasible due to geographic, economic, or other operational factors. An insurer must give special consideration to contracting with teaching hospitals and hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load.

(f) Network requirements. Each preferred provider benefit plan must include a health care service delivery network that complies with Insurance Code §1301.005 and §1301.006 and the local market adequacy requirements described in this section. An adequate network must:

(1) be sufficient, in number, size, and geographic distribution, to be capable of furnishing the preferred benefit health care services covered by the insurance contract within the insurer's designated service area, taking into account the number of insureds and their characteristics, medical, and health care needs, including the:

(A) current utilization of covered health care services within the prescribed geographic distances outlined in this section; and

(B) projected utilization of covered health care services;

(2) include an adequate number of preferred providers available and accessible to insureds 24 hours a day, seven days a week, within the insurer's designated service area;

(3) include sufficient numbers and classes of preferred providers to ensure choice, access, and quality of care across the insurer's designated service area;

(4) include an adequate number of preferred provider physicians who have admitting privileges at one or more preferred provider hospitals located within the insurer's designated service area to make any necessary hospital admissions;

(5) provide for necessary hospital services by contracting with general, special, and psychiatric hospitals on a preferred benefit basis within the insurer's designated service area, as applicable;

(6) provide, if covered, for physical and occupational therapy services and chiropractic services by preferred providers that are available and accessible within the insurer's designated service area;

(7) provide for emergency care that is available and accessible 24 hours a day, seven days a week, by preferred providers;

(8) provide for preferred benefit services sufficiently accessible and available as necessary to ensure that the distance from any point in the insurer's designated service area to a point of service is not greater than:

(A) 30 miles in nonrural areas and 60 miles in rural areas for primary care and general hospital care; and

(B) 75 miles for specialty care and specialty hospitals;

(9) ensure that covered urgent care is available and accessible from preferred providers within the insurer's designated service area within 24 hours for medical and behavioral health conditions;

(10) ensure that routine care is available and accessible from preferred providers:

(A) within three weeks for medical conditions; and

(B) within two weeks for behavioral health conditions;

(11) ensure that preventive health services are available and accessible from preferred providers:

(A) within two months for a child, or earlier if necessary for compliance with recommendations for specific preventive care services; and

(B) within three months for an adult.

(g) Network monitoring and corrective action. Insurers must monitor compliance with subsection (f) of this section on an ongoing basis, taking any needed corrective action as required to ensure that the network is adequate.

(h) Service areas. For purposes of this subchapter, a preferred provider benefit plan may have one or more contiguous or noncontiguous service areas, but any service areas that are smaller than statewide must be defined in terms of one of the following:

(1) one or more of the 11 Texas geographic regions designated in §3.3711 of this title (relating to Geographic Regions);

(2) one or more Texas counties; or

(3) the first three digits of ZIP Codes in Texas.

§3.3705. Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations.

(a) Readability. All health insurance policies, health benefit plan certificates, endorsements, amendments, applications or riders are required to be written in a readable and understandable format that meets the requirements of §3.602 of this chapter (relating to Plain Language Requirements).

(b) Disclosure of terms and conditions of the policy. The insurer is required, on request, to provide to a current or prospective group contract holder or a current or prospective insured an accurate

written description of the terms and conditions of the policy that allows the current or prospective group contract holder or current or prospective insured to make comparisons and informed decisions before selecting among health care plans. An insurer may utilize its handbook to satisfy this requirement provided that the insurer complies with all requirements set forth in this subsection including the level of disclosure required. The written description must be in a readable and understandable format, by category, and must include a clear, complete, and accurate description of these items in the following order:

(1) a statement that the entity providing the coverage is an insurance company; the name of the insurance company; that, in the case of a preferred provider benefit plan, the insurance contract contains preferred provider benefits; and, in the case of an exclusive provider benefit plan, that the contract only provides benefits for services received from preferred providers, except as otherwise noted in the contract and written description or as otherwise required by law;

(2) a toll free number, unless exempted by statute or rule, and address to enable a current or prospective group contract holder or a current or prospective insured to obtain additional information;

(3) an explanation of the distinction between preferred and nonpreferred providers;

(4) all covered services and benefits, including payment for services of a preferred provider and a nonpreferred provider, and prescription drug coverage, both generic and name brand;

(5) emergency care services and benefits and information on access to after-hours care;

(6) out-of-area services and benefits;

(7) an explanation of the insured's financial responsibility for payment for any premiums, deductibles, copayments, coinsurance or other out-of-pocket expenses for noncovered or nonpreferred services;

(8) any limitations and exclusions, including the existence of any drug formulary limitations, and any limitations regarding preexisting conditions;

(9) any authorization requirements, including preauthorization review, concurrent review, post-service review, and post-payment review; and any penalties or reductions in benefits resulting from the failure to obtain any required authorizations;

(10) provisions for continuity of treatment in the event of termination of a preferred provider's participation in the plan;

(11) a summary of complaint resolution procedures, if any, and a statement that the insurer is prohibited from retaliating against the insured because the insured or another person has filed a complaint on behalf of the insured, or against a physician or provider who, on behalf of the insured, has reasonably filed a complaint against the insurer or appealed a decision of the insurer;

(12) a current list of preferred providers and complete descriptions of the provider networks, including names and locations of physicians and health care providers, and a disclosure of which preferred providers will not accept new patients. Both of these items may be provided electronically, if notice is also provided in the disclosure required by this subsection regarding how a nonelectronic copy may be obtained free of charge;

(13) the service area(s); and

(14) information that is updated at least annually regarding the following network demographics for each service area, if the preferred provider benefit plan is not offered on a statewide service area basis, or for each of the 11 regions specified in §3.3711 of this title (relating to Geographic Regions), if the plan is offered on a statewide service area basis:

(A) the number of insureds in the service area or region;

(B) for each provider area of practice, including at a minimum internal medicine, family/general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery, the number of preferred providers, as well as an indication of whether an active access plan pursuant to §3.3709 of this title (relating to Annual Network Adequacy Report; Access Plan) applies to the services furnished by that class of provider in the service area or region and how such access plan may be obtained or viewed, if applicable; and

(C) for hospitals, the number of preferred provider hospitals in the service area or region, as well as an indication of whether an active access plan pursuant to §3.3709 of this title applies to hospital services in that service area or region and how the access plan may be obtained or viewed.

(15) information that is updated at least annually regarding whether any waivers or local market access plans approved pursuant to §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) apply to the plan and that complies with the following:

(A) if a waiver or a local market access plan applies to facility services or to internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, or general surgery services, this must be specifically noted;

(B) the information may be categorized by service area or county if the preferred provider benefit plan is not offered on a statewide service area basis, and, if by county, the aggregate of counties is not more than those within a region; or for each of the 11 regions specified in §3.3711 of this title (relating to Geographic Regions), if the plan is offered on a statewide service area basis; and

(C) the information must identify how to obtain or view the local market access plan.

(c) Filing required. A copy of the written description required in subsection (b) of this section must be filed with the department with the initial filing of the preferred provider benefit plan and within 60 days of any material changes being made in the information required in subsection (b) of this section. Submission of listings of preferred providers as required in subsection (b)(12) of this section may be made electronically in a format acceptable to the department or by submitting with the filing the Internet website address at which the department may view the current provider listing. Acceptable formats include Microsoft Word and Excel documents. Electronic submission of the provider listing, if applicable, must be submitted to the following email address: LifeHealth@tdi.texas.gov. Nonelectronic filings must be submitted to the department at: Life/Health and HMO Intake Team, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

(d) Promotional disclosures required. The preferred provider benefit plan and all promotional, solicitation, and advertising material concerning the preferred provider benefit plan must clearly describe the distinction between preferred and nonpreferred providers. Any illustration of preferred provider benefits must be in close proximity to an equally prominent description of basic benefits, except in the case of an exclusive provider benefit plan.

(e) Internet website disclosures. Insurers that maintain an Internet website providing information regarding the insurer or the health

insurance policies offered by the insurer for use by current or prospective insureds or group contract holders must provide:

(1) an Internet-based provider listing for use by current and prospective insureds and group contract holders;

(2) an Internet-based listing of the state regions, counties, or three-digit ZIP Code areas within the insurer's service area(s), indicating as appropriate for each region, county or ZIP Code area, as applicable, that the insurer has:

(A) determined that its network meets the network adequacy requirements of this subchapter; or

(B) determined that its network does not meet the network adequacy requirements of this subchapter; and

(3) an Internet-based listing of the information specified for disclosure in subsection (b) of this section.

(f) Notice of rights under a network plan required. An insurer must include the notice specified in Figure: 28 TAC §3.3705(f)(1), for a preferred provider benefit plan that is not an exclusive provider benefit plan, or Figure: 28 TAC §3.3705(f)(2), for an exclusive provider benefit plan, in all policies, certificates, disclosures of policy terms and conditions provided pursuant to subsection (b) of this section, and outlines of coverage in at least 12 point font:

(1) Preferred provider benefit plan notice.
Figure: 28 TAC §3.3705(f)(1)

(2) Exclusive provider benefit plan notice.
Figure: 28 TAC §3.3705(f)(2)

(g) Untrue or misleading information prohibited. No insurer, or agent or representative of an insurer, may cause or permit the use or distribution of information which is untrue or misleading.

(h) Disclosure concerning access to preferred provider listing. The insurer must provide notice to all insureds at least annually describing how the insured may access a current listing of all preferred providers on a cost-free basis. The notice must include, at a minimum, information concerning how to obtain a nonelectronic copy of the listing and a telephone number through which insureds may obtain assistance during regular business hours to find available preferred providers.

(i) Required updates of available provider listings. The insurer must ensure that it updates all electronic or nonelectronic listings of preferred providers made available to insureds at least every three months.

(j) Annual provision of provider listing required in certain cases. If no Internet-based preferred provider listing or other method of identifying current preferred providers is maintained for use by insureds, the insurer must distribute a current preferred provider listing to all insureds no less than annually by mail, or by an alternative method of delivery if an alternative method is agreed to by the insured, group policyholder on behalf of the group, or certificate holder.

(k) Reliance on provider listing in certain cases. A claim for services rendered by a nonpreferred provider must be paid in the same manner as if no preferred provider had been available under §3.3708(b) - (d) of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures) and §3.3725(d) - (f) of this title (relating to Payment of Certain Out-of-Network Claims), as applicable, if an insured demonstrates that:

(1) in obtaining services, the insured reasonably relied upon a statement that a physician or provider was a preferred provider as specified in:

(A) a provider listing; or

(B) provider information on the insurer's website;

(2) the provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by its insureds;

(3) the provider listing or website information was obtained not more than 30 days prior to the date of services; and

(4) the provider listing or website information obtained indicates that the provider is a preferred provider within the insurer's network.

(l) Additional listing-specific disclosure requirements. In all preferred provider listings, including any Internet-based postings of information made available by the insurer to provide information to insureds about preferred providers, the insurer must comply with the requirements in paragraphs (1) - (9) of this subsection.

(1) The provider information must include a method for insureds to identify those hospitals that have contractually agreed with the insurer to facilitate the usage of preferred providers as specified in subparagraphs (A) and (B) of this paragraph.

(A) The hospital will exercise good faith efforts to accommodate requests from insureds to utilize preferred providers.

(B) In those instances in which a particular facility-based physician or physician group is assigned at least 48 hours prior to services being rendered, the hospital will provide the insured with information that is:

(i) furnished at least 24 hours prior to services being rendered; and

(ii) sufficient to enable the insured to identify the physician or physician group with enough specificity to permit the insured to determine, along with preferred provider listings made available by the insurer, whether the assigned facility-based physician or physician group is a preferred provider.

(2) The provider information must include a method for insureds to identify, for each preferred provider hospital, the percentage of the total dollar amount of claims filed with the insurer by or on behalf of facility-based physicians that are not under contract with the insurer. The information must be available by class of facility-based physician, including radiologists, anesthesiologists, pathologists, emergency department physicians, and neonatologists.

(3) In determining the percentages specified in paragraph (2) of this subsection, an insurer may consider claims filed in a 12-month period designated by the insurer ending not more than 12 months before the date the information specified in paragraph (2) of this subsection is provided to the insured.

(4) The provider information must indicate whether each preferred provider is accepting new patients.

(5) The provider information must provide a method by which insureds may notify the insurer of inaccurate information in the listing, with specific reference to:

(A) information about the provider's contract status; and

(B) whether the provider is accepting new patients.

(6) The provider information must provide a method by which insureds may identify preferred provider facility-based physicians able to provide services at preferred provider facilities.

(7) The provider information must be provided in at least 10 point font.

(8) The provider information must specifically identify those facilities at which the insurer has no contracts with a class of facility-based provider, specifying the applicable provider class.

(9) The provider information must be dated.

(m) Annual policyholder notice concerning use of a local market access plan. An insurer operating a preferred provider benefit plan that relies on a local market access plan as specified in §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) must provide notice of this fact to each individual and group policyholder participating in the plan at policy issuance and at least 30 days prior to renewal of an existing policy. The notice must include:

(1) a link to any webpage listing of regions, counties, or ZIP codes made available pursuant to subsection (e)(2) of this section;

(2) information on how to obtain or view any local market access plan or plans the insurer uses; and

(3) a link to the department's website where the department posts information relevant to the grant of waivers.

(n) Disclosure of substantial decrease in the availability of certain preferred providers. An insurer is required to provide notice as specified in this subsection of a substantial decrease in the availability of preferred facility-based physicians at a preferred provider facility.

(1) A decrease is substantial if:

(A) the contract between the insurer and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates; or

(B) the contract between the facility and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates, and the insurer receives notice as required under §3.3703(a)(26) of this title (relating to Contracting Requirements).

(2) Notwithstanding paragraph (1) of this subsection, no notice of a substantial decrease is required if the requirements specified in either subparagraph (A) or (B) of this paragraph are met:

(A) alternative preferred providers of the same specialty as the physician group that terminates a contract as specified in paragraph (1) of this subsection are made available to insureds at the facility so the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease; or

(B) the insurer provides to the department, by e-mail to mcqa@tdi.texas.gov, a certification of the insurer's determination that the termination of the provider contract has not caused the preferred provider service delivery network for any plan supported by the network to be noncompliant with the adequacy standards specified in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers), as those standards apply to the applicable provider specialty.

(3) An insurer must prominently post notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and the resulting decrease in availability of preferred providers on the portion of the insurer's website where its provider listing is available to insureds.

(4) Notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and of the decrease in availability of providers must be maintained on the insurer's website until the earlier of:

(A) the date on which adequate preferred providers of the same specialty become available to insureds at the facility at the percentage level specified in paragraph (2)(A) of this subsection;

(B) six months from the date that the insurer initially posts the notice; or

(C) the date on which the insurer provides to the department, by e-mail to mcqa@tdi.texas.gov, a certification as specified in paragraph (2)(B) of this subsection indicating the insurer's determination that the termination of provider contract does not cause non-compliance with adequacy standards.

(5) An insurer must post notice as specified in paragraph (3) of this subsection and update its Internet-based preferred provider listing as soon as practicable and in no case later than two business days after:

(A) the effective date of the contract termination as specified in paragraph (1)(A) of this subsection; or

(B) the later of:

(i) the date on which an insurer receives notice of a contract termination as specified in paragraph (1)(B) of this subsection; or

(ii) the effective date of the contract termination as specified in paragraph (1)(B) of this subsection.

(o) Disclosures concerning reimbursement of out-of-network services. An insurer must make disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of out-of-network services as specified in this subsection.

(1) An insurer must disclose how reimbursements of nonpreferred providers will be determined.

(2) Except in an exclusive provider benefit plan, if an insurer reimburses nonpreferred providers based directly or indirectly on data regarding usual, customary, or reasonable charges by providers, the insurer must disclose the source of the data, how the data is used in determining reimbursements, and the existence of any reduction that will be applied in determining the reimbursement to nonpreferred providers.

(3) Except in an exclusive provider benefit plan, if an insurer bases reimbursement of nonpreferred providers on any amount other than full billed charges, the insurer must:

(A) disclose that the insurer's reimbursement of claims for nonpreferred providers may be less than the billed charge for the service;

(B) disclose that the insured may be liable to the nonpreferred provider for any amounts not paid by the insurer;

(C) provide a description of the methodology by which the reimbursement amount for nonpreferred providers is calculated; and

(D) provide to insureds a method to obtain a real time estimate of the amount of reimbursement that will be paid to a nonpreferred provider for a particular service.

(p) Plan designations. A preferred provider benefit plan that utilizes a preferred provider service delivery network that complies with the network adequacy requirements for hospitals under §3.3704 of this title without reliance on an access plan may be designated by the insurer as having an "Approved Hospital Care Network" (AHCN).

If a preferred provider benefit plan utilizes a preferred provider service delivery network that does not comply with the network adequacy requirements for hospitals specified in §3.3704 of this title, the insurer is required to disclose that the plan has a "Limited Hospital Care Network":

(1) on the insurer's outline of coverage; and

(2) on the cover page of any provider listing describing the network.

(q) Loss of status as an AHCN. If a preferred provider benefit plan designated as an AHCN under subsection (p) of this section no longer complies with the network adequacy requirements for hospitals under §3.3704 of this title and does not correct such noncompliant status within 30 days of becoming noncompliant, the insurer must:

(1) notify the department in writing concerning such change in status at Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104;

(2) cease marketing the plan as an AHCN; and

(3) inform all insureds of such change of status at the time of renewal.

§3.3707. Waiver Due to Failure to Contract in Local Markets.

(a) In accord with Insurance Code §1301.0055(3), where necessary to avoid a violation of the network adequacy requirements of §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers) in a portion of the state that the insurer wishes to include in its service area, an insurer may apply for a waiver from one or more of the network adequacy requirements in §3.3704(f) of this title. The commissioner may grant the waiver if there is good cause based on one or more of the criteria specified in this subsection and may impose reasonable conditions on the grant of the waiver. The commissioner may find good cause to grant the waiver if the insurer demonstrates that providers or physicians necessary for an adequate local market network:

(1) are not available to contract; or

(2) have refused to contract with the insurer on any terms or on terms that are reasonable.

(b) At a minimum, each waiver an insurer requests must include either the information specified by paragraph (1) of this subsection or the information specified by paragraph (2) of this subsection, as appropriate.

(1) If providers or physicians are available within the relevant service area for the covered service or services for which the insurer requests a waiver, the insurer's request for waiver must include:

(A) a list of the providers or physicians within the relevant service area that the insurer attempted to contract with, identified by name and specialty or facility type;

(B) a description of how and when the insurer last contacted each provider or physician;

(C) a description of any reason each provider or physician gave for refusing to contract with the insurer;

(D) an estimate of total claims cost savings per year the insurer anticipates will result from using a local market access plan instead of contracting with providers located within the service area, and its impact on premium; and

(E) steps the insurer will take to attempt to improve its network to make future requests to renew the waiver unnecessary.

(2) If no providers or physicians are available within the relevant service area for the covered service or services for which the insurer requests a waiver, the insurer's request for waiver must state this fact.

(c) At the same time an insurer files a request for waiver, it must file a local market access plan, as specified in subsection (i) of this section, to be taken into consideration by the commissioner in deciding whether to grant or deny a waiver request.

(d) An insurer seeking a waiver under subsection (a) of this section must electronically file the request with the department at the Office of the Chief Clerk through the following email address: chiefclerk@tdi.texas.gov. The insurer must also submit a copy of the request to any provider or physician named in the waiver request at the same time the insurer files the request with the department, but is permitted to redact information from the copy where provision of the information to the provider or physician would violate state or federal law. The insurer may use any reasonable means to submit the copy of the request to the provider or physician. The insurer must maintain proof of the submission and include a copy of the redacted version with the waiver request submitted to the department.

(e) Any provider or physician may elect to provide a response to an insurer's request for waiver by filing the response within 30 days after the insurer files the request with the department. The response, if filed, must be filed at the same address specified in subsection (d) of this section for filing the request for waiver.

(f) If the department grants a waiver under subsection (a) of this section, the department will post on the department's website information relevant to the grant of a waiver, including:

(1) the name of the preferred provider benefit plan for which the request is granted;

(2) the insurer offering the plan; and

(3) the affected service area.

(g) An insurer may apply for renewal of a waiver described in subsection (a) of this section annually.

(1) Application for renewal of a waiver must be filed in the manner described in subsection (d) of this section at least 30 days prior to the anniversary of the department's grant of waiver.

(2) At the same time the insurer files an application for renewal of a waiver, the insurer must file any applicable local market access plan the insurer uses pursuant to the waiver, in the manner specified by subsection (i)(2) of this section.

(3) A waiver granted by the department will remain in effect unless the insurer fails to timely file an annual application for renewal of the waiver or the department denies the application for renewal.

(h) A waiver will expire one year after the date the department granted it if an insurer fails to timely request a renewal under subsection (g) of this section or if the department denies the insurer's request for renewal.

(i) If the status of a network utilized in any preferred provider benefit plan changes so that the health benefit plan no longer complies with the network adequacy requirements specified in §3.3704 of this title for a specific service area, the insurer must establish a local market access plan within 30 days of the date on which the network becomes noncompliant and, within 90 days of the date on which the network becomes noncompliant, apply for a waiver pursuant to subsection (a) of this section requesting that the department approve the continued use of the local market access plan.

(1) The local market access plan must contain all the information specified in subsection (j) of this section.

(2) The insurer must file the local market access plan with the department by email at: mcqa@tdi.texas.gov or through the National Association of Insurance Commissioner's System for Electronic Rate and Form Filing.

(j) A local market access plan required under subsection (i) of this section must specify for each service area that does not meet the network adequacy requirements:

(1) the geographic area within the service area in which a sufficient number of preferred providers are not available as specified in §3.3704 of this title, including a specification of the class of provider that is not sufficiently available;

(2) a map, with key and scale, that identifies the geographic areas within the service area in which the health care services, physicians, or providers are not available;

(3) the reason(s) that the preferred provider network does not meet the adequacy requirements specified in §3.3704 of this title;

(4) procedures that the insurer will utilize to assist insureds in obtaining medically necessary services when no preferred provider is reasonably available, including procedures to coordinate care to limit the likelihood of balance billing; and

(5) procedures detailing how out-of-network benefit claims will be handled when no preferred or otherwise contracted provider is available, including procedures for compliance with §3.3708 of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures) and §3.3725 of this title (relating to Payment of Certain Out-of-Network Claims).

(k) An insurer must establish and implement documented procedures, as specified in this subsection, for use in all service areas for which a local market access plan is submitted.

(1) The insurer must utilize a documented procedure to:

(A) identify requests for preauthorization of services for insureds that are likely to require the rendition of services by physicians or providers that do not have a contract with the insurer;

(B) furnish to insureds, prior to the services being rendered, an estimate of the amount the insurer will pay the physician or provider; and

(C) except in the case of an exclusive provider benefit plan, notify insureds that they may be liable for any amounts charged by the physician or provider that are not paid in full by the insurer.

(2) The insurer must utilize a documented procedure to:

(A) identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured; and

(B) make initial and, if required, subsequent payment of the claims in the manner required by this subchapter.

(l) A local market access plan may include a process for negotiating with a nonpreferred provider prior to services being rendered, when feasible.

(m) An insurer must submit a local market access plan established pursuant to this section as a part of the annual report on network adequacy required under §3.3709 of this title (relating to Annual Network Adequacy Report).

(n) An insurer that is granted a waiver under this section concerning network adequacy requirements for hospital based services is required to comply with §3.3705(p) of this title (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations). The insurer is required to designate such plan as having a "Limited Hospital Care Network".

§3.3708. Payment of Certain Basic Benefit Claims and Related Disclosures.

(a) An insurer must comply with the requirements of subsections (b) and (c) of this section when a preferred provider is not reasonably available to an insured and services are instead rendered by a nonpreferred provider, including circumstances:

(1) requiring emergency care;

(2) when no preferred provider is reasonably available within the designated service area for which the policy was issued; and

(3) when a nonpreferred provider's services were pre-approved or preauthorized based upon the unavailability of a preferred provider.

(b) When services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured under subsection (a) of this section, the insurer must:

(1) pay the claim, at a minimum, at the usual or customary charge for the service, less any patient coinsurance, copayment, or deductible responsibility under the plan;

(2) pay the claim at the preferred benefit coinsurance level; and

(3) in addition to any amounts that would have been credited had the provider been a preferred provider, credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for charges for covered services that were above and beyond the allowed amount toward the insured's deductible and annual out-of-pocket maximum applicable to in-network services.

(c) Reimbursements of all nonpreferred providers for services that are covered under the health insurance policy are required to be calculated pursuant to an appropriate methodology that:

(1) if based upon usual, reasonable, or customary charges, is based on generally accepted industry standards and practices for determining the customary billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs;

(2) if based on claims data, is based upon sufficient data to constitute a representative and statistically valid sample;

(3) is updated no less than once per year;

(4) does not use data that is more than three years old; and

(5) is consistent with nationally recognized and generally accepted bundling edits and logic.

(d) An insurer is required to pay all covered basic benefits for services obtained from health care providers or physicians at least at the plan's basic benefit level of coverage, regardless of whether the service is provided within the designated service area for the plan. Provision of services by health care providers or physicians outside the designated service area for the plan shall not be a basis for denial of a claim.

(e) When services are rendered to an insured by a nonpreferred facility-based physician and the difference between the allowed amount and the billed charge is at least $1,000, the insurer must include a notice on the applicable explanation of benefits that the insured may

have the right to request mediation of the claim of an uncontracted facility-based provider under Insurance Code Chapter 1467 and may obtain more information at www.tdi.texas.gov/consumer/cpmmediation.html. An insurer is not in violation of this subsection if it provides the required notice in connection with claims that are not eligible for mediation.

(f) This section does not apply to an exclusive provider benefit plan.

§3.3709. Annual Network Adequacy Report.

(a) Network adequacy report required. An insurer must file a network adequacy report with the department on or before April 1 of each year and prior to marketing any plan in a new service area.

(b) General content of report. The report required in subsection (a) of this section must specify:

(1) the trade name of each preferred provider benefit plan in which insureds currently participate;

(2) the applicable service area of each plan; and

(3) whether the preferred provider service delivery network supporting each plan is adequate under the standards in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers).

(c) Additional content applicable only to annual reports. As part of the annual report on network adequacy, each insurer must provide additional demographic data as specified in paragraphs (1) - (6) of this subsection for the previous calendar year. The data must be reported on the basis of each of the geographic regions specified in §3.3711 of this title (relating to Geographic Regions). If none of the insurer's preferred provider benefit plans includes a service area that is located within a particular geographic region, the insurer must specify in the report that there is no applicable data for that region. The report must include the number of:

(1) claims for out-of-network benefits, excluding claims paid at the preferred benefit coinsurance level;

(2) claims for out-of-network benefits that were paid at the preferred benefit coinsurance level;

(3) complaints by nonpreferred providers;

(4) complaints by insureds relating to the dollar amount of the insurer's payment for basic benefits or concerning balance billing;

(5) complaints by insureds relating to the availability of preferred providers; and

(6) complaints by insureds relating to the accuracy of preferred provider listings.

(d) Filing the report. The annual report required under this section must be submitted electronically in a format acceptable to the department. Acceptable formats include Microsoft Word and Excel documents. The report must be submitted to the following email address: LifeHealth@tdi.texas.gov.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300428

Sara Waitt
General Counsel
Texas Department of Insurance
Effective date: February 21, 2013
Proposal publication date: November 2, 2012
For further information, please call: (512) 463-6327

DIVISION 2. EXCLUSIVE PROVIDER BENEFIT PLAN REQUIREMENTS

28 TAC §§3.3720 - 3.3725

STATUTORY AUTHORITY. The department adopts the amendments and new sections under Insurance Code §§1301.003, 1301.0042, 1301.007, 1301.005, 1301.006, 1301.0051, 1301.0052, 1301.0053, 1301.0055,1301.0056, 1301.1581, 1701.055, 1201.006, 1201.101, 1201.102, 1251.008, 1456.006, 1456.003, 1501.010, and 36.001.

Insurance Code §1301.003 provides that an exclusive provider benefit plan that meets the requirements of Chapter 1301, relating to Preferred Provider Benefit Plans, is not unjust under Insurance Code Chapter 1701; unfair discrimination under Insurance Code Chapter 55, Subchapter A or B; or a violation of Insurance Code, Chapter 1451, Subchapter B or C.

Insurance Code §1301.0042 provides that, except for dental care benefits, a provision of the Insurance Code or other insurance law that applies to a preferred provider benefit plan also applies to an exclusive provider benefit plan, except to the extent that the commissioner determines the provision is inconsistent with the function and purpose of an exclusive provider benefit plan. Insurance Code §1301.0042 also authorizes the commissioner to determine whether a provision is inconsistent with the function and purpose of an exclusive provider benefit plan.

Insurance Code §1301.007 authorizes the commissioner to adopt rules to implement Insurance Code Chapter 1301, relating to Preferred Provider Benefit Plans, and to ensure reasonable accessibility and availability of preferred provider services to residents of this state.

Insurance Code §1301.005 provides that an insurer must reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider if services are not available through a preferred provider within a designated service area under a preferred provider benefit plan.

Insurance Code §1301.006 requires that an insurer that markets a preferred provider benefit plan contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities.

Insurance Code §1301.0051 provides that an insurer that offers an exclusive provider benefit plan must establish procedures to ensure that health care services are provided to insureds under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of care or practice.

Insurance Code §1301.0052 provides that if a covered service is medically necessary and is not available through a preferred provider, the issuer of an exclusive provider benefit plan, on the request of a preferred provider must approve the referral of an insured to a nonpreferred provider within a reasonable period and fully reimburse the nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider. Insurance Code §1301.0052 also requires an exclusive provider benefit plan to provide for a review by a health care provider with expertise in the same specialty as or a specialty similar to the type of health care provider to whom a referral is requested before the issuer of the plan may deny the referral.

Insurance Code §1301.0053 provides that if a nonpreferred provider provides emergency care as defined by Insurance Code §1301.155 to an insured in an exclusive provider benefit plan, the issuer of the plan must reimburse the nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider for the provision of the services.

Insurance Code §1301.0055 requires the commissioner to adopt by rule network adequacy standards that: (i) are adapted to local markets where an insurer offers a preferred provider benefit plan; (ii) ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health services to insureds; and (iii) on good cause shown, may allow departure from local market network adequacy standards if the commissioner posts on the department's website the name of the preferred provider plan, the insurer offering the plan, and the affected local market.

Insurance Code §1301.0056 authorizes the commissioner to examine an insurer to determine the quality and adequacy of a network used by an exclusive provider benefit plan offered by the insurer under this chapter and requires an insurer examined under the section to pay the cost of the examination in an amount determined by the commissioner.

Insurance Code §1301.1581 requires an insurer that offers an exclusive provider benefit plan to provide to a current or prospective group contract holder or current or prospective insured notice that the benefit plan includes limited coverage for services provided by a physician or health care provider that is not a preferred provider.

Insurance Code §1701.055(a)(2) authorizes the commissioner to disapprove or, after notice and hearing, withdraw approval of a form if the form contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive, subject to the exception specified in subsection (d) of the section.

Insurance Code §1201.006 authorizes the commissioner to adopt reasonable rules as necessary to implement Insurance Code Chapter 1201.

Insurance Code §1201.101 and §1201.102 authorize the commissioner to adopt rules specifying the content of an individual accident and health insurance policy and to prohibit provisions in individual accident and health insurance policies that the commissioner determines to be unjust, unfair, or unfairly discriminatory.

Insurance Code §1251.008 authorizes the commissioner to adopt rules necessary to administer the group health insurance chapter of the Insurance Code.

Insurance Code §1456.006 authorizes the commissioner to adopt by rule specific requirements for the health benefit plan disclosure required under §1456.003.

Insurance Code §1501.010 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1501, the Health Insurance Portability and Availability Act.

Insurance Code §36.001 provides that the commissioner of insurance may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

§3.3720. Exclusive Provider Benefit Plan Requirements.

The provisions of this division apply only to exclusive provider benefit plans offered pursuant to Insurance Code Chapter 1301 in commercial markets.

§3.3721. Exclusive Provider Benefit Plan Network Approval Required.

An insurer may not offer, deliver, or issue for delivery an exclusive provider benefit plan in this state unless the commissioner has completed a qualifying examination to determine compliance with Insurance Code Chapter 1301 and this subchapter and has approved the insurer's exclusive provider network in the service area.

§3.3722. Application for Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications.

(a) Where to file application. An insurer that seeks to offer an exclusive provider benefit plan must file an application for approval with the Texas Department of Insurance at the following address: Texas Department of Insurance, Mail Code 106-1A, P.O. Box 149104, Austin, Texas 78714-9104. A form titled Application for Approval of Exclusive Provider Benefit Plan is available on the department's website at www.tdi.texas.gov/forms. An insurer may use this form to prepare the application.

(b) Filing requirements.

(1) An applicant must provide the department with a complete application that includes the elements in the order set forth in subsection (c) of this section.

(2) All pages must be clearly legible and numbered.

(3) If the application is revised or supplemented during the review process, the applicant must submit a transmittal letter describing the revision or supplement plus the specified revision or supplement.

(4) If a page is to be revised, a complete new page must be submitted with the changed item or information clearly marked.

(c) Contents of application. A complete application includes the elements specified in paragraphs (1) - (12) of this subsection.

(1) The applicant must provide a statement that the filing is:

(A) an application for approval; or

(B) a modification to an approved application.

(2) The applicant must provide organizational information for the applicant, including:

(A) the full name of the applicant;

(B) the applicant's Texas Department of Insurance license or certificate number;

(C) the applicant's home office address, including city, state, and ZIP code; and

(D) the applicant's telephone number.

(3) The applicant must provide the name and telephone number of an individual to be the contact person who will facilitate requests from the department regarding the application.

(4) The applicant must provide an attestation signed by the applicant's corporate president, corporate secretary, or the president's or secretary's authorized representative that:

(A) the person has read the application, is familiar with its contents, and asserts that all of the information submitted in the application, including the attachments, is true and complete; and

(B) the network, including any requested or granted waiver and any access plan as applicable, is adequate for the services to be provided under the exclusive provider benefit plan.

(5) The applicant must provide a description and a map of the service area, with key and scale, identifying the area to be served by geographic region(s), county(ies), or ZIP code(s). If the map is in color, the original and all copies must also be in color.

(6) The applicant must provide a list of all plan documents and each document's associated form filing ID number or the form number of each plan document that is pending the department's approval or review.

(7) The applicant must provide the form(s) of physician contract(s) and provider contract(s) that include the provisions required in §3.3703 of this title (relating to Contracting Requirements) or an attestation by the insurer's corporate president, corporate secretary, or the president's or secretary's authorized representative that the physician and provider contracts applicable to services provided under the exclusive provider benefit plan comply with the requirements of Insurance Code Chapter 1301 and this subchapter.

(8) The applicant must provide a description of the quality improvement program and work plan that includes a process for medical peer review required by Insurance Code §1301.0051 and that explains arrangements for sharing pertinent medical records between preferred providers and for ensuring the records' confidentiality.

(9) The applicant must provide network configuration information, including:

(A) maps for each specialty demonstrating the location and distribution of the physician and provider network within the proposed service area by geographic region(s), county(ies) or ZIP code(s); and

(B) lists of:

(i) physicians and individual providers who are preferred providers, including license type and specialization and an indication of whether they are accepting new patients; and

(ii) institutional providers that are preferred providers.

(10) The applicant must provide documentation demonstrating that its plan documents and procedures are compliant with §3.3725(a) of this title (relating to Payment of Certain Out-of-Network Claims) and that the policy contains, without regard to whether the physician or provider furnishing the services has a contractual or other arrangement to provide items or services to insureds, the provisions and procedures for coverage of emergency care services as set forth in §3.3725 of this title.

(11) The applicant must provide documentation demonstrating that the insurer maintains a complaint system that provides reasonable procedures to resolve a written complaint initiated by a complainant.

(12) The applicant must provide notification of the physical address of all books and records described in subsection (d) of this section.

(d) Qualifying examinations; documents to be available. The following documents must be available during the qualifying examination at the physical address designated by the insurer pursuant to subsection (c)(12) of this section:

(1) quality improvement--program description and work plan as required by §3.3724 of this title (relating to Quality Improvement Program);

(2) utilization management--program description, policies and procedures, criteria used to determine medical necessity, and examples of adverse determination letters, adverse determination logs, and independent review organization logs;

(3) network configuration information demonstrating adequacy of the exclusive provider network, as outlined in subsection (c)(9) of this section, and all executed physician and provider contracts applicable to the network, which may be satisfied by contract forms and executed signature pages;

(4) credentialing files;

(5) all written materials to be presented to prospective insureds that discuss the exclusive provider network available to insureds under the plan and how preferred and nonpreferred physicians or providers will be paid under the plan;

(6) the policy and certificate of insurance; and

(7) a complaint log that is categorized and completed in accord with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions).

(e) Network modifications.

(1) An insurer must file an application for approval with the department before the insurer may make changes to network configuration that impact the adequacy of the network, expand an existing service area, reduce an existing service area, or add a new service area.

(2) Pursuant to paragraph (1) of this subsection, if an insurer submits any of the following items to the department and then replaces or materially changes them, the insurer must submit the new item or any amendments to an existing item along with an indication of the changes:

(A) descriptions and maps of the service area, as required by subsection (c)(5) of this section;

(B) forms of contracts, as described in subsection (c) of this section; or

(C) network configuration information, as required by subsection (c)(9) of this section.

(3) Before the department grants approval of a service area expansion or reduction application, the insurer must comply with the requirements of §3.3724 of this title in the existing service areas and in the proposed service areas.

(4) An insurer must file with the department any information other than the information described in paragraph (2) of this subsection that amends, supplements, or replaces the items required under subsection (c) of this section no later than 30 days after the implementation of any change.

§3.3723. Examinations.

(a) The commissioner may conduct an examination relating to an exclusive provider benefit plan as often as the commissioner considers necessary, but no less than once every five years.

(b) On-site financial, market conduct, complaint, or quality of care exams will be conducted pursuant to Insurance Code Chapter 401, Subchapter B; Insurance Code Chapter 751; and §7.83 of this title (relating to Appeal of Examination Reports).

(c) An insurer must make its books and records relating to its operations available to the department to facilitate an examination.

(d) On request of the commissioner, an insurer must provide to the commissioner a copy of any contract, agreement, or other arrangement between the insurer and a physician or provider. Documentation provided to the commissioner under this subsection will be maintained as confidential as specified in Insurance Code §1301.0056.

(e) The commissioner may examine and use the records of an insurer, including records of a quality of care program and records of a medical peer review committee, as necessary to implement the purposes of this subchapter, including commencement and prosecution of an enforcement action under Insurance Code Title 2, Subtitle B, and §3.3710 of this title (relating to Failure to Provide an Adequate Network). Information obtained under this subsection will be maintained as confidential as specified in Insurance Code §1301.0056. In this subsection, "medical peer review committee" has the meaning assigned by the Occupations Code §151.002.

(f) The following documents must be available for review at the physical address designated by the insurer pursuant to §3.3722(c)(12) of this title (relating to Application for Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications):

(1) quality improvement--program description, work plans, program evaluations, and committee and subcommittee meeting minutes;

(2) utilization management--program description, policies and procedures, criteria used to determine medical necessity, and templates of adverse determination letters; adverse determination logs, including all levels of appeal; and utilization management files;

(3) complaints--complaint files and complaint logs, including documentation and details of actions taken. All complaints must be categorized and completed in accord with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions);

(4) satisfaction surveys--any insured, physician, and provider satisfaction surveys, and any insured disenrollment and termination logs;

(5) network configuration information as required by §3.3722(c)(9) of this title demonstrating adequacy of the exclusive provider network;

(6) credentialing--credentialing files; and

(7) reports--any reports the insurer submits to a governmental entity.

§3.3724. Quality Improvement Program.

(a) An insurer must develop and maintain an ongoing quality improvement (QI) program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services provided within an exclusive provider benefit plan and to pursue opportunities for improvement. The QI program must be continuous and comprehensive, addressing both the quality of clinical care and the quality of services. The insurer must dedicate adequate resources, like personnel and information systems, to the QI program.

(1) Written description. The QI program must include a written description of the QI program that outlines program organizational structure, functional responsibilities, and meeting frequency.

(2) Work plan. The QI program must include an annual QI work plan designed to reflect the type of services and the population served by the exclusive provider benefit plan in terms of age groups, disease categories, and special risk status. The work plan must:

(A) include objective and measurable goals, planned activities to accomplish the goals, time frames for implementation, responsible individuals, and evaluation methodology; and

(B) address each program area, including:

(i) network adequacy, which includes availability and accessibility of care, including assessment of open and closed physician and individual provider panels;

(ii) continuity of medical and health care and related services;

(iii) clinical studies;

(iv) the adoption and periodic updating of clinical practice guidelines or clinical care standards that:

(I) are approved by participating physicians and individual providers;

(II) are communicated to physicians and individual providers; and

(III) include preventive health services;

(v) insured, physician, and individual provider satisfaction;

(vi) the complaint process, complaint data, and identification and removal of barriers that may impede insureds, physicians, and providers from effectively making complaints against the insurer;

(vii) preventive health care through health promotion and outreach activities;

(viii) claims payment processes;

(ix) contract monitoring, including oversight and compliance with filing requirements;

(x) utilization review processes;

(xi) credentialing;

(xii) insured services; and

(xiii) pharmacy services, including drug utilization.

(3) Evaluation. The QI program must include an annual written report on the QI program, which includes completed activities, trending of clinical and service goals, analysis of program performance, and conclusions.

(4) Credentialing. An insurer must implement a documented process for selection and retention of contracted preferred providers that complies with §3.3706(c) of this title (relating to Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process).

(5) Peer review. The QI program must provide for a peer review procedure for physicians and individual providers, as required in the Medical Practice Act, Occupations Code Chapters 151 - 164.

The insurer must designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

(b) The insurer's governing body is ultimately responsible for the QI program.

(1) The governing body must appoint a quality improvement committee (QIC) that:

(A) must include practicing physicians and individual providers;

(B) may include one or more insured(s) from throughout the exclusive provider benefit plan's service area; and

(C) must ensure that any insured appointed to the QIC is not an employee of the insurer.

(2) The governing body must approve the QI program.

(3) The governing body must approve an annual QI plan.

(4) The governing body must meet no less than annually to receive and review reports of the QIC or its subcommittees and take action when appropriate.

(5) The governing body must review the annual written report on the QI program.

(c) The QIC must evaluate the overall effectiveness of the QI program.

(1) The QIC may delegate QI activities to other committees that may, if applicable, include practicing physicians, individual providers, and insureds from the service area.

(A) All committees must collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services.

(B) All committees must meet regularly and report the findings of each meeting, including any recommendations, in writing to the QIC.

(C) If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.

(2) The QIC must use multidisciplinary teams, when indicated, to accomplish QI program goals.

(d) In reviewing an insurer's quality improvement program, the department will presume that the insurer is in compliance with statutory and regulatory requirements regarding the insurer's quality improvement program if the insurer has received nonconditional accreditation or certification specific and germane to the insurer's quality improvement program by the National Committee for Quality Assurance, the Joint Commission, URAC, or the Accreditation Association for Ambulatory Health Care. However, if the department determines that an accreditation or certification program does not adequately address a material Texas statutory or regulatory requirement, the department will not presume the insurer to be in compliance with that requirement.

§3.3725. Payment of Certain Out-of-Network Claims.

(a) If an insured cannot reasonably reach a preferred provider, the insurer must fully reimburse a nonpreferred provider for the following emergency care services at the usual and customary rate or at a rate agreed to by the insurer and the nonpreferred provider until the insured can reasonably be expected to transfer to a preferred provider:

(1) a medical screening examination or other evaluation required by state or federal law to be provided in a hospital emergency facility of a hospital, freestanding emergency medical care facility, or comparable facility that is necessary to determine whether a medical emergency condition exists;

(2) necessary emergency care services, including the treatment and stabilization of an emergency medical condition; and

(3) following treatment or stabilization of an emergency medical condition, services originating in a hospital emergency facility or freestanding emergency medical care facility or comparable emergency facility.

(b) If medically necessary covered services, excluding emergency care, are not available through a preferred provider upon the request of a preferred provider, the insurer must:

(1) approve a referral to a nonpreferred provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation; and

(2) provide for a review by a health care provider with expertise in the same specialty as or a specialty similar to the type of health care provider to whom a referral is requested under paragraph (1) of this subsection before the insurer may deny the referral.

(c) An insurer may facilitate an insured's selection of a nonpreferred provider when medically necessary covered services, excluding emergency care, are not available through a preferred provider and an insured has received a referral from a preferred provider.

(1) If an insurer chooses to facilitate an insured's selection of a nonpreferred provider pursuant to this subsection, the insurer must offer an insured a list of at least three nonpreferred providers with expertise in the necessary specialty who are reasonably available considering the medical condition and location of the insured.

(2) If the insured selects a nonpreferred provider from the list provided by the insurer, subsections (d) - (f) of this section are applicable.

(3) If the insured selects a nonpreferred provider that is not included in the list provided by the insurer, then:

(A) subsections (d) - (f) of this section are not applicable; and

(B) notwithstanding §3.3708(f) of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures), the insurer must pay the claim in accord with §3.3708 of this title.

(d) An insurer reimbursing a nonpreferred provider under subsection (a), (b), or (c)(2) of this section must ensure that the insured is held harmless for any amounts beyond the copayment, deductible, and coinsurance percentage that the insured would have paid had the insured received services from a preferred provider.

(e) Upon determining that a claim from a nonpreferred provider under subsection (a), (b), or (c)(2) of this section is payable, an insurer must issue payment to the nonpreferred provider at the usual and customary rate or at a rate agreed to by the insurer and the nonpreferred provider. When issuing payment, the insurer must provide an explanation of benefits to the insured along with a request that the insured notify the insurer if the nonpreferred provider bills the insured for amounts beyond the amount paid by the insurer.

(1) The insurer must resolve any amounts that the nonpreferred provider bills the insured beyond the amount paid by the insurer in a manner consistent with subsection (d) of this section.

(2) The insurer may require in its policy or certificate issued to an insured that, if a claim is eligible for mediation under Insurance Code Chapter 1467 and Chapter 21, Subchapter PP of this title (relating to Out-of-Network Claim Dispute Resolution), the insured must request mediation.

(A) The insurer must notify the insured when mediation is available under Insurance Code Chapter 1467 and Chapter 21, Subchapter PP of this title, and inform the insured of how to request mediation.

(i) The insurer may not require that the insured participate in a mediation requested under Insurance Code Chapter 1467 and Chapter 21, Subchapter PP of this title.

(ii) The insurer may not penalize the insured for failing to request mediation.

(iii) Notwithstanding clause (ii) of this subparagraph, after the insurer requests that the insured initiate mediation, the insurer is not responsible for any balance bill the insured receives from the provider, until the insured requests mediation.

(B) For purposes of determining eligibility for mediation under Insurance Code Chapter 1467 and Chapter 21, Subchapter PP of this title the entire unpaid amount of the amount the nonpreferred provider bills should be taken into consideration, less any applicable copayment, deductible, and coinsurance.

(C) If the amount of a claim is changed as a result of mediation required by the insurer, the insurer's payment must be based on the amount that results from the mediation process.

(f) Any methodology utilized by an insurer to calculate reimbursements of nonpreferred providers for services that are covered under the health insurance policy must comply with the following:

(1) if based on usual, reasonable, or customary charges, the methodology must be based on generally accepted industry standards and practices for determining the customary billed charge for a service and fairly and accurately reflect market rates, including geographic differences in costs;

(2) if based on claims data, the methodology must be based on sufficient data to constitute a representative and statistically valid sample;

(3) any claims data underlying the calculation must be updated no less than once per year and not include data that is more than three years old; and

(4) the methodology must be consistent with nationally recognized and generally accepted bundling edits and logic.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300429
Sara Waitt
General Counsel
Texas Department of Insurance
Effective date: February 21, 2013
Proposal publication date: November 2, 2012
For further information, please call: (512) 463-6327

♦ ♦ ♦

SUBCHAPTER X. PREFERRED PROVIDER PLANS

28 TAC §3.3713

INTRODUCTION. The Texas Department of Insurance adopts the repeal of 28 TAC §3.3713, which requires an insurer to develop, submit to the department, and implement a plan to collect and analyze information from health care facilities on the effects of undercompensated care. The repeal is adopted without changes to the proposal published in the November 2, 2012, issue of the *Texas Register* (37 TexReg 8717).

REASONED JUSTIFICATION. Undercompensated care issues in Texas are undergoing considerable change as a result of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152, and the grant by the federal government of a waiver under Section 1115 of the Social Security Act (Title 42 U.S.C. Section 1315) of certain Medicaid regulations. The many changes will affect how facilities will be reimbursed, and may alter the amount of undercompensated care. As changes are implemented, the market in Texas will continue to evolve, substantially reducing the usefulness of the data that would be collected pursuant to §3.3713. Repealing the section will allow insurers and other actors in the health care market to work on maintaining a stable insurance and health care service market. The department will continue to monitor the issue of undercompensated care to determine whether regulatory action is needed.

HOW THE SECTION WILL FUNCTION. The adoption of the repeal of the section will remove a detailed data collection and analysis requirement at a time when insurers and other actors in the health care market are working to maintain a stable insurance and health care service market.

SUMMARY OF COMMENTS. The department did not receive any comments on the proposed repeal.

STATUTORY AUTHORITY. The repeal of §3.3713 is adopted pursuant to Insurance Code §1301.007 and §36.001. Section 1301.007 provides that the commissioner of insurance must adopt rules as necessary to implement Chapter 1301. Section 36.001 provides that the commissioner of insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300430
Sara Waitt
General Counsel
Texas Department of Insurance
Effective date: February 21, 2013
Proposal publication date: November 12, 2012
For further information, please call: (512) 463-6327

♦ ♦ ♦

CHAPTER 19. AGENTS' LICENSING

INTRODUCTION. The Texas Department of Insurance adopts the repeal of Subchapter R, §§19.1701 - 19.1724, concerning utilization review agents, and Subchapter U, §§19.2001 - 19.2021, concerning utilization reviews for health care provided under workers' compensation insurance coverage.

The repeal of the sections is adopted without changes to the proposal published in the August 24, 2012, issue of the *Texas Register* (37 TexReg 6464).

REASONED JUSTIFICATION. Repeal of §§19.1701 - 19.1717, 19.1720, 19.1721, 19.1723, and 19.1724 is necessary to incorporate the requirements in those sections and Insurance Code Chapter 4201 into adopted new Subchapter R, §§19.1701 - 19.1719. Repeal of §§19.2001 - 19.2017, 19.2020, and 19.2021 is necessary to incorporate the requirements in those sections and Insurance Code Chapter 4201 into adopted new Subchapter U, §§19.2001 - 19.2017.

Repeal of §19.1718 and §19.2018, concerning criminal penalties, is necessary because the statute on which they were based, Insurance Code Article 21.58A §10, was repealed by Senate Bill 14, 77th Legislature, Regular Session, effective September 1, 2001. Repeal of §19.1719, concerning responsibility of HMOs and insurers performing utilization review under Insurance Code Article 21.58A, §14(g) and (h), and §19.2019, concerning responsibility of insurance companies performing utilization review under Insurance Code Article 21.58A, §14(h), is necessary because the requirements already exist in Insurance Code §§4201.057, 4201.058, and 4201.053, and repeating the requirements in the adopted new rules would be redundant. Repeal of §19.1722, concerning the utilization review advisory committee, is necessary because the utilization review agents' advisory committee was abolished by House Bill 1951, 82nd Legislature, Regular Session, effective September 1, 2011.

HOW THE SECTIONS WILL FUNCTION. In conjunction with this adoption, the commissioner of insurance is adopting new Subchapter R, §§19.1701 - 19.1719, and Subchapter U, §§19.2001 - 19.2017, also published in this issue of the *Texas Register.*

SUMMARY OF COMMENTS AND AGENCY RESPONSE. TDI did not receive any comments on the proposed repeal.

SUBCHAPTER R. UTILIZATION REVIEW AGENTS

28 TAC §§19.1701 - 19.1724

STATUTORY AUTHORITY. Repeal of §19.1718 and §19.1722 is adopted under SB 14, 77th Legislature, Regular Session, effective September 1, 2001, and HB 1951, 82nd Legislature, Regular Session, effective September 1, 2011. SB 14 repealed Article 21.58A, Section 10, which was the statutory basis for §19.1718. HB 1951 abolished the utilization review agents' advisory committee, which was the basis for §19.1722. Repeal of §§19.1701 - 19.1717, 19.1719 - 19.1721, 19.1723, and 19.1724 is adopted under Insurance Code §4201.003 and §36.001. Section 4201.003 provides that the commissioner may adopt rules to implement Chapter 4201 of the Insurance Code. Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 31, 2013.

TRD-201300373
Sara Waitt
General Counsel
Texas Department of Insurance
Effective date: February 20, 2013
Proposal publication date: August 24, 2012
For further information, please call: (512) 463-6327

♦ ♦ ♦

SUBCHAPTER U. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER WORKERS' COMPENSATION INSURANCE COVERAGE

28 TAC §§19.2001 - 19.2021

STATUTORY AUTHORITY. Repeal of §19.2018 is adopted under SB 14, 77th Legislature, Regular Session, effective September 1, 2001, and HB 1951, 82nd Legislature, Regular Session, effective September 1, 2011. SB 14 repealed Article 21.58A, Section 10, which was the statutory basis for §19.2018. Repeal of §§19.2001 - 19.2017 and 19.2019 - 19.2021 is adopted under Insurance Code §4201.003 and §36.001. Section 4201.003 provides that the commissioner may adopt rules to implement Chapter 4201 of the Insurance Code. Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 31, 2013.

TRD-201300374
Sara Waitt
General Counsel
Texas Department of Insurance
Effective date: February 20, 2013
Proposal publication date: August 24, 2012
For further information, please call: (512) 463-6327

♦ ♦ ♦

CHAPTER 19. AGENTS' LICENSING

INTRODUCTION. The Texas Department of Insurance adopts §§19.1701 - 19.1719, concerning utilization reviews for health care provided under a health benefit plan or health insurance policy (referred to as Subchapter R, collectively), and §§19.2001 - 19.2017, concerning utilization reviews for health care provided under workers' compensation insurance coverage (referred to as Subchapter U, collectively). Sections 19.1701 - 19.1709, 19.1711, 19.1713, 19.1714, 19.1717, 19.1718, 19.2002 - 19.2006, 19.2008 - 19.2014, and 19.2017 are adopted

with changes to the proposed text published in the August 24, 2012, issue of the *Texas Register* (37 TexReg 6466). Sections 19.1710, 19.1712, 19.1715, 19.1716, 19.1719, 19.2001, 19.2007, 19.2015, and 19.2016 are adopted without changes to the proposed text.

In conjunction with this adoption order, TDI is adopting the repeal of existing Subchapter R, §19.1701, concerning general provisions; §19.1702, concerning limitations on applicability; §19.1703, concerning definitions; §19.1704, concerning certification of utilization review agents; §19.1705, concerning general standards of utilization review; §19.1706, concerning personnel; §19.1707, concerning prohibitions of certain activities of utilization review agents; §19.1708, concerning utilization review agent contact with and receipt of information from health care providers; §19.1709, concerning on-site review by the utilization review agent; §19.1710, concerning notice of determinations made by utilization review agents; §19.1711, concerning requirements prior to adverse determination; §19.1712, concerning appeal of adverse determination of utilization review agents; §19.1713, concerning utilization review agent's telephone access; §19.1714, concerning confidentiality; §19.1715, concerning retrospective review of medical necessity; §19.1716, concerning complaints and information; §19.1717, concerning administrative violations; §19.1718, concerning criminal penalties; §19.1719, concerning responsibility of HMOs and insurers performing utilization review under Insurance Code Article 21.58A, §14(g) and (h); §19.1720, concerning specialty utilization review agent; §19.1721, concerning independent review of adverse determinations; §19.1722, concerning Utilization Review Advisory Committee; §19.1723, concerning preauthorization; and §19.1724, concerning verification.

In addition, TDI is adopting the repeal of existing Subchapter U, §19.2001, concerning general provisions; §19.2002, concerning limitations on applicability; §19.2003, concerning definitions; §19.2004, concerning certification of utilization review agents; §19.2005, concerning general standards of utilization review; §19.2006, concerning personnel; §19.2007, concerning prohibitions of certain activities of utilization review agents; §19.2008, concerning utilization review agent contact with and receipt of information from health care providers; §19.2009, concerning on-site review by the utilization review agent; §19.2010, concerning notice of determinations made by utilization review agents, excluding retrospective review; §19.2011, concerning requirements prior to adverse determination; §19.2012, concerning appeal of adverse determination of utilization review agents; §19.2013, concerning utilization review agent's telephone access; §19.2014, concerning confidentiality; §19.2015, concerning retrospective review of medical necessity; §19.2016, concerning complaints and reporting requirements; §19.2017, concerning administrative violations; §19.2018, concerning criminal penalties; §19.2019, concerning responsibility of insurance companies performing utilization review under Insurance Code Article 21.58A, §14(h); §19.2020, concerning specialty utilization review agent; and §19.2021, concerning independent review organizations non-involvement. The adoption of the repeal of Subchapters R and U is also published in this issue of the *Texas Register.*

In addition to the changes made as a result of comments, TDI revised references from "form No. LHL005 URA application" to "URA Application" in §§19.1703(b), 19.1704(b)(1), (b)(2), (d), and (h), 19.2003(b), 19.2004(b)(1), (b)(2), (d), and (h) to conform to current agency style. TDI revised references from "form No. 11 biographical affidavit" to "biographical affidavit" in §§19.1703(b), 19.1704(b), and 19.2003(b). As a conforming change, TDI redesignated the definitions under §19.1703(b) and §19.2003(b). TDI changed the word "or" to "and" before the phrases "the facilities rendering care," and "the plan of treatment prescribed by the provider of record" in §19.1707(b)(1) for consistency with Subchapter U. TDI revised references from "form No. LHL009 request for a review by an IRO" to "request for a review by an IRO" in §§19.1703(b); 19.1709(b)(7), (b)(8)(A), and (8)(B); 19.1711(a)(8)(G); 19.1717(a)(1) and (c); 19.2003(b); 19.2009(b)(9)(A)(i), (B)(i), and (B)(ii); 19.2011(a)(7)(D); 19.2017(a)(1)(C); and 19.2017(b). TDI added the word "or" and deleted a comma before the phrase "an individual acting on behalf of the enrollee," and changed the word "or" to "and" before the phrase "the enrollee's provider of record" in §19.1718(h), to clarify that the notice must be provided to the enrollee or an individual acting on behalf of the enrollee, and the enrollee's provider of record.

Additionally, TDI has adopted numerous non-substantive changes throughout the text of Subchapters R and U. These non-substantive changes include conforming to current agency style, reformatting, amending for consistency and clarity, and correcting typographical and grammatical errors.

The following paragraphs include a detailed, section-by-section description and reasoned justification of all of the amendments necessary to implement House Bill 4290 and to make the other changes that TDI and the Division of Workers' Compensation determined are necessary for effective compliance with and effective implementation and enforcement of Insurance Code Chapter 4201.

REASONED JUSTIFICATION.

These new sections are necessary to implement HB 4290, 81st Legislature, Regular Session, effective September 1, 2009, which revises the definitions of "adverse determination" and "utilization review" in Insurance Code Chapter 4201 to include retrospective reviews and determinations regarding the experimental or investigational nature of a service. The new sections also make other changes necessary for clarity, effective implementation, and enforcement of Insurance Code Chapter 4201. The entire adoption order is part of the reasoned justification for the new sections.

The commissioner of insurance and the commissioner of workers' compensation, in their joint statement to the members of the Utilization Review Advisory Committee dated February 10, 2010, stressed that although Subchapters R and U address a function that is provided in both the health and workers' compensation systems, the rules derive from a common statute, Insurance Code Chapter 4201. Insurance Code §4201.054(a) states, "Except as provided by this section, {Chapter 4201} applies to utilization review of a health care service provided to a person eligible for workers' compensation medical benefits under Title 5, Labor Code. The commissioner of workers' compensation shall regulate as provided by this chapter a person who performs utilization review of a medical benefit provided under Title 5, Labor Code." Under Insurance Code §4201.054(c), Labor Code Title 5 prevails in the event of a conflict between Insurance Code Chapter 4201 and Labor Code Title 5. Under Insurance Code §1305.351, Insurance Code Chapter 1305 prevails in the event of a conflict between Insurance Code Chapters 4201 and 1305. Insurance Code Chapter 4201, to the extent it is not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305, applies to workers' compensation utilization review.

The expertise of both TDI and TDI-DWC staff was utilized throughout the rulemaking process, and workers' compensation stakeholder feedback was considered and incorporated throughout the open meetings of the Utilization Review Advisory Committee and the informal draft and proposal process. TDI and TDI-DWC have determined that Subchapter R and Subchapter U rules should be consistent whenever possible for the benefit of both regulated entities and consumers. Because there are statutes that specifically govern utilization review for workers' compensation coverage, there are differences between Subchapter R and Subchapter U rules as needed to implement and maintain consistency with the relevant statutes. However, because there are URAs that might be subject to both subchapters, TDI and TDI-DWC recognize the importance of consistency for ease of interpretation and compliance. Uniform standards offer a more consistent and efficient utilization review process for enrollees and injured employees, who are equally entitled to the highest quality of utilization review.

House Bill 4290

House Bill 4290 amends the definition of "utilization review" to specifically include retrospective review of the medical necessity and appropriateness of health care services. House Bill 4290 further amends the term to include a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services.

The Senate Committee on State Affairs' Bill Analysis for HB 4290 specifies the legislative intent of HB 4290:

"...{C}urrent law does not require an independent review of a carrier's conclusion that treatment should be denied because it is experimental or investigational. In addition, current law does not provide for an independent review of a carrier's conclusion after the fact that a treatment was not medically necessary.

"Health plans may deny a requested service for the reason that the plan deems it to be experimental or investigational, and the provider or claimant does not have access to an administrative process to seek review both prospectively and retroactively through a process coordinated by TDI. . . . Texas is the only state with limitations on retrospective reviews of denials based on medical necessity and the only state with an independent review law that does not extend to retrospective reviews of at least emergency and urgent care.

"TDI has received numerous complaints regarding these issues, but there is little TDI can do to address them. Carriers have varying standards for what is considered experimental and investigational and, in regard to retrospective reviews, TDI's data regarding workers' compensation claim denials show that carriers incorrectly issue retrospective denials more often than prospective denials, with retrospective medical necessity decisions, including experimental and investigational denials, overturned 68% of the time after an independent review is conducted, while prospective medical necessity decisions are overturned approximately 30% of the time.

"C.S.H.B. 4290 amends current law relating to retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service."

TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report, Substituted), C.S.H.B. 4290, 81st Leg., R.S. (May 12, 2009).

TDI conducted a public hearing on the published rule proposal on September 26, 2012, under Docket Number 2740. In response to written comments on the proposal and comments made at the hearing, TDI made several changes; however, none of the changes made in this adoption to the proposed text or proposed form materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

Subchapters R and U new sections.

Section 19.1701 and §19.2001 address General Provisions. Section 19.1701(a) and §19.2001(a) change the existing provisions relating to the statutory basis for the rules in Subchapter R and Subchapter U, respectively, to reflect that the new subchapters incorporate the most recent amendments to Insurance Code Chapter 4201. Additionally, §19.2001(a) incorporates the most recent amendments to Insurance Code Chapter 1305 and to Labor Code Title 5. Section 19.1701(b) and §19.2001(b) amend the existing severability clause language to conform to current agency style. Section 19.1701(c) and §19.2001(c) track Insurance Code §4201.001, with the addition of the word "medical" as a clarifying change in §19.1701(c)(4) and §19.2001(c)(4).

Section 19.1702 and §19.2002 address Applicability. Section 19.1702(a) provides that Texas Administrative Code Title 28, Chapter 19, Subchapter R, applies to utilization review performed under a health benefit plan or a health insurance policy and does not apply to utilization review performed under workers' compensation insurance coverage. Section 19.2002(a) specifies that Subchapter U applies to utilization review performed under workers' compensation insurance coverage, as set forth in Insurance Code Chapters 1305 and 4201, and Labor Code Title 5, and does not affect the authority of TDI-DWC to exercise the powers granted to it under Labor Code Title 5 and Insurance Code Chapter 4201. These subsections are necessary to state the applicability of Subchapters R and U.

Section 19.1702(a)(1) and §19.2002(a)(1), relating to the nonapplicability of Subchapters R and U, respectively, track Insurance Code §4201.051. Section 19.1702(a)(2) and §19.2002(a)(2) clarify that a person performing administrative tasks for a URA, who does not determine medical necessity or appropriateness, or the experimental or investigational nature, of the health care services, is not subject to the requirements under Subchapter R or U, respectively. Insurance Code §4201.101 provides that a URA may not conduct utilization review unless the commissioner issues a certificate of registration to the agent under Insurance Code Chapter 4201, Subchapter C. Utilization review is defined in Insurance Code §4201.002(13), which provides that utilization review includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services; and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.

Section 19.1702(b) explains that provisions of Insurance Code Chapter 843, concerning Health Maintenance Organizations; Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans; Insurance Code Chapter 1352, concerning Brain Injury; and Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services, apply to new Subchapter R. Insurance Code §4201.053 provides that Chapter 4201 does not apply to the state Medicaid program. However, Subchapter R does apply to the Texas Children's Health Insurance Program.

Section 19.2002(b)(1) provides that health care providers performing peer reviews regarding the prospective, concurrent, or retrospective review of the medical necessity or appropriateness of health care are performing utilization review and must generate a written report. The subsection requires health care providers to comply with Subchapter U; Labor Code Title 5; and rules adopted under the Texas Workers' Compensation Act, including monitoring and enforcement provisions. This new provision clarifies that some peer reviews are utilization review.

Section 19.2002(b)(2) provides that insurance carriers must process medical bills as required by Labor Code Title 5 and rules adopted under the Texas Workers' Compensation Act including Chapter 133, Subchapter A of this title (relating to General Rules for Medical Billing and Processing). This provision clarifies that these adopted rules do not exempt insurance carriers from TDI-DWC's medical billing rules or otherwise modify insurance carriers' duties under those rules.

To implement Insurance Code §4201.054(c), §19.2002(b)(3) provides that if there is a conflict between Subchapter U and rules adopted by the commissioner of workers' compensation, the rules adopted by the commissioner of workers' compensation prevail. These required new rules are consistent with Insurance Code §4201.054(a), which states that except as provided by Insurance Code §4201.054, Insurance Code Chapter 4201 applies to utilization review of a health care service provided to a person eligible for workers' compensation medical benefits under Labor Code Title 5. Additionally, Insurance Code §4201.054(c) provides that Labor Code Title 5 prevails in the event of a conflict between Insurance Code Chapter 4201 and Labor Code Title 5.

Section 19.2002(b)(4) provides that if there is a conflict between the URA rules and the certified health care network rules adopted by TDI, the rules adopted for networks in 28 TAC Chapter 10 prevail. The rules for workers' compensation health care networks in 28 TAC Chapter 10 implement Insurance Code Chapter 1305. Insurance Code §1305.351(a) provides that in the event of a conflict between Insurance Code Chapter 4201 and Insurance Code Chapter 1305, Chapter 1305 prevails.

Section 19.1703 and §19.2003 address Definitions. Section 19.1703(a) and §19.2003(a) provide that the terms defined in Insurance Code Chapter 4201 have the same meaning when used in adopted new Subchapter R and Subchapter U rules, respectively.

The definition of "adverse determination" in §19.1703(b)(1) and §19.2003(b)(1) adds the phrase "made on behalf of any payor" to the definition of "adverse determination" in Insurance Code §4201.002(1) to clarify TDI's position that the definition includes determinations made on behalf of all payors, including payors that conduct utilization review in-house.

Further, the definitions of "adverse determination" in Subchapters R and U specifically implement HB 4290. Insurance Code §4201.002(1) defined "adverse determination," prior to the enactment of HB 4290, to mean a URA's determination that health care services provided or proposed to be provided to a patient are not medically necessary or appropriate, but the provision was not interpreted to include retrospective review of medical necessity. This interpretation was based on the definition of "utilization review" in Insurance Code §4201.002(13) as a system for "prospective or concurrent" review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to an individual in this state. After the enactment of HB 4290, the definitions of "adverse determination" and "utilization review" were revised in Insurance Code Chapter 4201 to include retrospective reviews and determinations regarding the experimental or investigational nature of a service.

Additionally, §19.1703(b)(1) and §19.2003(b)(1) add the provision that the term "adverse determination" does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. This change is necessary to clarify that a denial of health care services for which the enrollee or injured employee, respectively, should have sought prospective or concurrent utilization review is not within the scope of the term.

The definition in §19.2003(b)(1) also clarifies that, for the purposes of Subchapter U, an adverse determination does not include a determination that health care services are experimental or investigational. Although this clarification is inconsistent with the statutory definition of "adverse determination" under Insurance Code §4201.002(1), it is consistent with Labor Code §408.021 and §413.014. Insurance Code §4201.054 provides that, in the event of a conflict, Labor Code Title 5 prevails. It is TDI's and TDI-DWC's position that based on Labor Code §408.021, an injured employee under both network and non-network coverage is entitled to all medically necessary health care services, including experimental and investigational health care services.

Labor Code §408.021 entitles an injured employee, under both network coverage and non-network coverage, to health care reasonably required by the nature of the injury as and when needed. Although injured employees under non-network coverage are entitled to experimental and investigational services, those services must be preauthorized under Labor Code §413.014, relating to preauthorization requirements, concurrent review, and certification of health care.

Despite this difference in the definition of the term "adverse determination" under Insurance Code Chapter 4201 and Labor Code Chapter 408, it is necessary that Subchapter U contain provisions relating to the experimental or investigational nature of care in the context of utilization review. Even though the determination that a health care service is experimental or investigational does not in itself constitute an adverse determination, only a URA should make determinations that health care services are experimental or investigational, based on the definition of "utilization review."

The definition of "appeal" in §19.1703(b)(2) and §19.2003(b)(2) updates the existing definition and clarifies that the term refers to the URA's formal process in which an enrollee, or an injured employee, respectively, their representative, or provider of record may request reconsideration of an adverse determination. Section 19.2003(b)(2) also provides that the term includes reconsideration processes prescribed by Labor Code Title 5 and applicable rules for workers' compensation.

Section 19.1703(b)(3) and §19.2003(b)(3) define the term "biographical affidavit" as the form that must be submitted to TDI as an attachment to the URA application form. The application form requires the name, biographical affidavit, and a complete set of fingerprints for each director, officer, and executive of the applicant, as required under 28 TAC §1.503 (relating to Application of Fingerprint Requirement) and 28 TAC §1.504 (relating to Fingerprint Requirement). The biographical form is necessary because, under 28 TAC §1.502(c) and (e), TDI developed guidelines relating to the matters that TDI will consider in determining

whether to grant, deny, suspend, or revoke any license or authorization under its jurisdiction. These matters include criminal background checks for each director, officer, and executive of the applicant.

The definition of the term "certificate" in §19.1703(b)(4) and §19.2003(b)(4) is more detailed and accurate than the existing definition to reflect that an insurance carrier or Health Maintenance Organization may be certified or registered, but that a "certificate" is not issued to an insurance carrier or HMO that is registered as a URA under §19.1704 or §19.2004, respectively.

The §19.1703(b)(5) and §19.2003(b)(5) definition of "commissioner" is as defined in Insurance Code §31.001, which provides that "In this code and other insurance laws: (1) "Commissioner" means the commissioner of insurance."

In §19.2003(b)(6), the term "compensable injury" is as defined in Labor Code §401.011, which provides that "Compensable injury means an injury that arises out of and in the course and scope of employment for which compensation is payable under this subtitle."

Section 19.1703(b)(6) and §19.2003(b)(7) define "complaint" as an oral or written expression of dissatisfaction with a URA concerning the URA's process in conducting a utilization review. The term "complaint" does not include: (A) an expression of dissatisfaction constituting an appeal under Insurance Code §4201.351, or (B) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to the satisfaction of the complaining party. This definition is necessary to track statutory language in Insurance Code §4201.351 and clarify that a misunderstanding promptly resolved to the complaining party's satisfaction does not constitute disagreement with an adverse determination or an appeal.

Section 19.1703(b)(7) and §19.2003(b)(8) define "concurrent utilization review" as a form of utilization review that is subject to these rules.

Section 19.1703(b)(8) defines "declination" and tracks existing §19.1703(9) with changes to replace the word "carrier" with "benefit plan" for clarity. The definition is necessary to clarify the term as used in §19.1719.

Section 19.1703(b)(9) and §19.2003(b)(9) define the term "disqualifying association" to ensure a consistent application in identifying situations in which conflicts of interest may exist for health care providers performing utilization review. The definition of "disqualifying association" includes any association that may reasonably be perceived as having the potential to influence the conduct or decision of a reviewing physician, doctor, or other health care provider. For example, the reasonableness standard can be used to evaluate whether a personal or family relationship may be considered a disqualifying association and is more flexible than a detailed list of specific family relationships that are always considered to be disqualifying associations. The prohibition against disqualifying associations is necessary to prevent a reviewing physician, doctor, or other health care provider from directly or indirectly exercising bias, prejudice, or preferential treatment of determinations made by health care providers performing utilization review.

Section 19.1703(b)(10) and §19.2003(b)(10) define the term "doctor." This definition mirrors the definition in existing 28 TAC §19.2003(12) and tracks the statutory language in Labor Code §401.011(17).

Section 19.1703(b)(11) and §19.2003(b)(11) define the term "experimental or investigational." This definition is consistent with Labor Code §413.014(a), 28 TAC §134.600, and 28 TAC §12.5(12). This definition is necessary to ensure a uniform application of the term. To the extent a health plan defines the term "experimental or investigational" differently than the rules, the definition set forth in the rules will control. TDI and TDI-DWC determined that a common definition ensures that enrollees or injured employees, regardless of the plan under which they receive coverage, are treated similarly with respect to determinations on the experimental or investigational nature of care. TDI defined this new term based on its general rulemaking authority under Insurance Code §4201.003 to adopt rules to implement Insurance Code Chapter 4201.

Section 19.2003(b)(12) defines the term "health care" and changes the existing definition in §19.2003(13) to include "a medical or surgical supply, appliance, brace, artificial member, or prosthetic or orthotic device, including the fitting of, change or repair to, or training in the use of the appliance, brace, member, or device," for consistency with the definition in Labor Code §401.011.

Section 19.1703(b)(12) and §19.2003(b)(13) define the term "health care facility." This definition is consistent with Labor Code §401.011(20).

Section 19.1703(b)(13) defines the term "health coverage" to provide a uniform understanding and application of what constitutes "health coverage" under the Subchapter R rules.

Section 19.1703(b)(14) defines the term "health maintenance organization or HMO" and references the statutory definition in Insurance Code §843.002.

Section 19.1703(b)(15) and §19.2003(b)(14) define the term "insurance carrier or insurer." The definitions are not identical, because the §19.2003(14) definition references workers' compensation insurance, which is not applicable under §19.1703(15).

Section 19.1703(b)(16) and §19.2003(b)(15) define the term "independent review organization or IRO" and reference the definition in 28 TAC §12.5.

Section 19.1703(b)(17) and §19.2003(b)(16) define the term "legal holiday" in accord with the definition of a "national holiday" in Government Code §662.003(a).

Section 19.2003(b)(17) defines the term "medical benefit" and references the statutory definition in Labor Code §401.011.

Section 19.2003(b)(18) defines the term "medical emergency" and tracks the definition in Insurance Code §1305.004(13), with a clarifying change from the use of the term "patient" to the term "injured employee." The definition in §19.2003(b)(18) also mirrors the definition of the term "emergency" in 28 TAC Chapter 133 (relating to General Medical Provisions), §133.2(a)(4)(A), adopted to be effective May 2, 2006.

The §19.1703(b)(18) and §19.2003(b)(19) definition of "medical records" is based on the definition of "medical records" in Insurance Code §1305.004(14), which defines the term for purposes of the Workers' Compensation Health Care Network Act. The definition of the term "medical records" from Insurance Code §1305.004(14) was also changed in new §19.1703(b)(18) and §19.2003(b)(19) to include the phrase "mental health records as allowed by law." The addition of the phrase "mental health records as allowed by law" was recommended by the Utilization Review Advisory Committee and is necessary to ensure the

availability of mental health records as allowed. This new rule is adopted under the commissioner's authority to adopt rules to implement Chapter 4201 under Insurance Code §4201.003(a).

Section 19.1703(b)(19) and §19.2003(b)(20) define the term "mental health medical record summary." The Utilization Review Advisory Committee recommended adding this definition to the Subchapter U rules for uniform application and consistency with the Subchapter R rules.

Section 19.1703(b)(20) and §19.2003(b)(21) define the term "mental health therapist." This definition incorporates the Utilization Review Advisory Committee recommendation to add the qualifier "as appropriate" to indicate that not all of the individuals licensed under subparagraphs (A) - (H) are authorized to diagnose, evaluate, and treat any mental or emotional condition or disorder.

Section 19.1703(b)(21) and §19.2003(b)(22) define the term "mental or emotional condition or disorder." The definition of the term "mental or emotional condition or disorder" in existing §19.1703(22) was amended for new Subchapter R and Subchapter U to delete the phrase "revision of the" to clarify that the most current Diagnostic and Statistical Manual of Mental Disorders must be used, rather than just the new "revision" because both new "editions" and new "revisions" of the manual are published.

Section 19.2003(b)(23) defines the term "payor." For purposes of Subchapter R, the statutory definition under Insurance Code §4201.002(10) is used. For purposes of Subchapter U, in new §19.2003(b)(23), TDI and TDI-DWC tailored the definition of "payor" to include a person or entity that provides, offers to provide, or administers workers' compensation benefits, in recognition that the definition of "payor" under Subchapters R and U should not be identical. The clarifying change under Insurance Code §4201.002(10) is not in conflict with Insurance Code Chapter 1305 or Labor Code Title 5. The references to "payor" are also necessary because the rules specifically distinguish between insurance carriers based on whether or not they are the payor. The term "payor" is also necessary for consistency with the IRO rules under 28 TAC §12.1, which contemplate an IRO's interaction with URAs and payors.

Section 19.2003(b)(24) defines the term "peer review." This definition was recommended by the Utilization Review Advisory Committee. TDI and TDI-DWC clarify that the requirements contained in Subchapter U do not apply to peer reviews performed for issues other than the review of medical necessity or appropriateness of health care. For example, the requirements in Subchapter U do not apply to compensability or an injured employee's ability to return to work. Section 19.2002(b)(1) specifies, in part, that:

Health care providers performing peer reviews regarding the prospective, concurrent, or retrospective review of the medical necessity or appropriateness of health care are performing utilization review and must generate a written report. Peer reviewers must comply with this subchapter, Labor Code Title 5, and rules adopted under the Texas Workers' Compensation Act including, but not limited to, Chapter 180 of this title, relating to Monitoring and Enforcement.

This provision describes requirements for peer reviews performed for the evaluation of medical necessity or appropriateness of health care and does not apply to peer reviews performed for other issues, for example, extent of injury issues.

Section 19.1703(b)(22) and §19.2003(b)(25) define the term "person" for uniform application of Subchapter R and Subchapter U rules.

Section 19.1703(b)(23) and §19.2003(b)(26) define the term "preauthorization." The definition in existing §19.1703(29) is changed in adopted §19.1703(b)(23) and §19.2003(b)(26) to add the descriptor "form of prospective utilization review by a payor or its URA of . . ." to incorporate by reference reviews of medical necessity and appropriateness, which are included in the definition of "utilization review" in Insurance Code §4201.002(14). A separate reference to reviews of medical necessity and appropriateness in the definition of "preauthorization" is unnecessary.

Section 19.1703(b)(24) defines the term "preferred provider" and changes the existing definition in §19.1703(30) to use the term "benefit plan" instead of "carrier" for clarity and uniform implementation.

Section 19.1703(b)(25) and §19.2003(b)(27) define the term "provider of record" to closely track Insurance Code §4201.002(12). Changes are made to clarify that a doctor is included among the persons that do not necessarily have to render care, treatment, or services to be considered the provider of record. Section 19.1703(b)(25) and §19.2003(b)(27) also replace the terminology "care, treatment, and services" from Insurance Code §4201.002(12) with "health care services" for consistency with other uses of this phrase throughout the text. Insurance Code Chapter 4201, to the extent not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305, applies to workers' compensation utilization review. Insurance Code §4201.003(a) grants the commissioner general rulemaking authority to implement Insurance Code Chapter 4201. There is no direct conflict with the use of "provider of record" and Labor Code Title 5, and TDI has the rulemaking authority to define and utilize the term "provider of record" throughout the Subchapter U rules.

Section 19.1703(b)(26) and §19.2003(b)(28) define the term "reasonable opportunity" as "at least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination: (A) no less than one working day prior to issuing a prospective utilization review adverse determination; (B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or (C) prior to issuing a concurrent or post-stabilization review adverse determination."

The definition of the term "reasonable opportunity" in new §19.1703(b)(26) and §19.2003(b)(28) recognizes the incompatibility of timeframes for concurrent utilization review and post-stabilization review. Under Insurance Code §843.348 and §1301.135, an HMO or preferred provider benefit plan must issue and transmit a determination for proposed medical or health care services for concurrent hospitalization care within 24 hours of receipt of the request. Additionally, an HMO or preferred provider benefit plan must issue and transmit a determination for proposed medical care or health care services involving post-stabilization treatment within one hour from receipt of the request.

It is often hard to get a provider of record on the phone with a URA when a call is made at the last minute before the adverse

determination is issued. The definition of "reasonable opportunity" in §19.1703(b)(26) and §19.2003(b)(28) maximizes the opportunity for the provider of record to address the concerns and discuss the services under review with the URA prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination.

The required timeframes for notification of the adverse determination for workers' compensation non-network coverage must be provided within the timeframes specified by 28 TAC §134.600. Section 134.600(i) requires a decision for preauthorization requests within three working days and a decision for certain requests for concurrent review within one working day of receipt of the request.

Notification of the adverse determination for workers' compensation network coverage must be provided within the timeframes specified by Insurance Code §1305.353 and 28 TAC §10.102. Under Insurance Code §1305.353(d), the URA must generally issue a determination on a preauthorization request not later than the third working day after the receipt of the request. However, under Insurance Code §1305.353(e), if the proposed services are for concurrent hospitalization care, the URA must transmit a determination within 24 hours of receipt of the request. Under Insurance Code §1305.353(f), if the proposed health care services involve post-stabilization treatment or a life-threatening condition, the URA must transmit a determination within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, not to exceed one hour from receipt of the request. Title 28 TAC §10.102 reiterates these statutory requirements.

Based on these timeframes, the URA must issue a determination for requests for prospective review no later than the third working day. This three-working-day timeframe is compatible with the requirement that the provider of record be afforded no less than one working day to discuss the determination. However, for concurrent review, TDI recognizes that requiring one working day for the peer-to-peer discussion may prevent the URA from providing the determination within the required 24-hour timeframe. Additionally, for post-stabilization treatment requests, TDI recognizes that requiring one working day for the peer-to-peer discussion may prevent the URA from providing the determination within the required one-hour timeframe.

Under Insurance Code §4201.305, the URA must provide notice of a retrospective review adverse determination within a reasonable time, but not later than 30 days after the date on which the claim is received. Under Insurance Code §4201.305(b), this period may be extended once for a period not to exceed 15 days, if the URA takes certain additional steps. Because of the longer time granted to URAs to issue determinations when conducting retrospective utilization review, TDI and TDI-DWC determined that five working days is a reasonable time to afford the provider of record to discuss the determination. These new sections are implementing the required peer-to-peer discussion statutory requirements under Insurance Code §4201.206. These new sections are adopted under TDI's general rulemaking authority under both Insurance Code §36.001 and §4201.003 to implement Insurance Code Chapter 4201.

Section 19.1703(b)(27) and §19.2003(b)(29) define the term "registration." Insurers performing utilization review only for coverage for which they are the payors are not subject to certification requirements but instead must register. The new definition clarifies that the registration process only applies to an insurer that performs utilization review solely for its own insureds or injured employees.

Section 19.1703(b)(28) and §19.2003(b)(30) define the term "request for a review by an IRO" as a request for a review by an independent review organization form. This form is completed by the requesting party and submitted to the URA or insurance carrier that made the adverse determination. This definition is consistent with Insurance Code §4201.303(a)(4), which requires a URA to include a notice to the enrollee of their right to appeal an adverse determination to an IRO and of the procedures to obtain that review. The definition is also consistent with Insurance Code 4201.359(a)(3), which requires notice of the appealing party's right to notice of the procedures for obtaining review of a denial by an IRO.

Section 19.1703(b)(29) and §19.2003(b)(31) define the term "retrospective utilization review." These sections change the definition in existing §19.1703(32) and §19.2003(28) and incorporate the term "utilization review" into the definition. Because reviews of "medical necessity and appropriateness" are included in the scope of "utilization review," separate internal reference to reviews of "medical necessity and appropriateness" are deleted. The addition of the sentence "Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted" clarifies that health care services that require preauthorization are not subject to retrospective review.

Section 19.1703(b)(30) defines the term "routine vision services" and tracks existing §19.1703(33).

Section 19.1703(b)(31) and §19.2003(b)(32) define the term "screening criteria." The new definition tracks existing §19.1703(34) and deletes the reference to "(e.g., appropriateness evaluation protocol (AEP) and intensity of service; severity of illness; discharge; and appropriateness screens (ISD-A))" because screening criteria must meet the requirements of Insurance Code §4201.153, and the examples provided in the definition are redundant.

Section 19.1703(b)(32) and §19.2003(b)(33) define the term "TDI" as the Texas Department of Insurance.

Section 19.2003(b)(34) defines the term "TDI-DWC" as the Texas Department of Insurance, Division of Workers' Compensation.

Section 19.2003(b)(35) defines the term "Texas Workers' Compensation Act" as Labor Code Title 5, Subtitle A.

Section 19.2003(b)(36) defines the term "treating doctor" to track the definition in Labor Code §401.011.

Section 19.1703(b)(33) and §19.2003(b)(37) define the term "URA."

Section 19.1703(b)(34) and §19.2003(b)(38) define the term "URA application" to clarify that the form is to be used to apply for certification or registration as a URA in Texas, for renewal of a certification or registration, and also to report a material change to a certification or registration form previously submitted to TDI. Insurance Code §4201.104 authorizes the commissioner to promulgate forms to be filed under Insurance Code Chapter 4201, Subchapter C, for initial certification. Additionally, this definition clarifies the use of the form and implements Insurance Code §4201.107, which provides that a URA must report any material change to the information disclosed in a form filed

under Subchapter C of Chapter 4201 not later than the 30th day after the date the change takes effect.

Section 19.1703(35) defines the term "verification" and replaces the term "carrier" in existing §19.1703(39) with the term "benefit plan" for clarity and consistency.

Section 19.2003(b)(39) defines the term "workers' compensation health care network." This definition is consistent with Insurance Code §1305.004(16).

Section 19.2003(b)(40) defines the term "workers' compensation health plan" to reference the applicability of a political subdivision contracting directly with health care providers or through a health benefits pool under Labor Code §504.053 to Subchapter U.

Section 19.2003(b)(41) defines the term "workers' compensation insurance coverage" to track the definition in Labor Code §401.011.

Section 19.2003(b)(42) defines the term "workers' compensation network coverage" and §19.2003(43) defines the term "workers' compensation non-network coverage."

Section 19.1704 and §19.2004 address Certification or Registration of URAs. The change to the title of existing §19.2004 reflects the application of the section to persons holding a "registration" as a URA. Section 19.1704(a) and §19.2004(a), added to implement Insurance Code §4201.101, provide that a person acting as or holding itself out as a URA must be certified or registered under Insurance Code Chapter 4201; 28 TAC Chapter 19, Subchapter R; or 28 TAC Chapter 19, Subchapter U, respectively. Section 4201.101 provides that a URA may not conduct utilization review unless the commissioner issues a certificate of registration to the agent under Chapter 4201, Subchapter C.

Section 19.1704(a)(1) and (2) and §19.2004(a)(1) and (2) are necessary to address certification and registration requirements for HMOs and insurers. Section 19.1704(a)(1) and §19.2004(a)(1) provide that if an HMO or insurer performs utilization review for an individual or entity subject to the subchapter for which it is not the payor, the HMO or insurer must have a valid certificate as required by Insurance Code §4201.101. This provision is consistent with Insurance Code §4201.057(e) and §4201.058(c).

Section 19.1704(a)(2) and §19.2004(a)(2) provide that if an HMO or insurer performs utilization review only for coverage for which it is the payor, the HMO or insurer must have a valid registration.

Section 19.1704(b) and §19.2004(b) specify the URA application requirements for both certification and registration. Section 19.1704(b) and §19.2004(b) adopt by reference the URA application, which is to be used for initial certification or registration, renewal of a certification or registration as a URA in this state, or to report a material change. Subsection (b)(1) provides that the URA application form must be used to apply for URA certification or registration. Subsection (b)(2) provides that the application form requires the biographical affidavit be submitted as an attachment to the application. The forms are adopted under the commissioner's authority to both promulgate forms under Insurance Code §4201.104 and to adopt rules to implement Chapter 4201 under §4201.003. Subsections (b) and (c) distinguish between the form and fee filing requirements for these two types of application.

Section 19.1704(c) and §19.2004(c) provide that an application for certification must be accompanied by the original application fee in the amount specified by §19.802, and that this fee requirement does not apply to an applicant for registration.

Section 19.1704(d) and §19.2004(d) provide information on where to obtain and send the application form.

Section 19.1704(e) and §19.2004(e) address the original application requirements and process, and are adopted under TDI's general rulemaking authority in Insurance Code §4201.003(a). Section 19.1704(e) and §19.2004(e) also clarify that TDI will issue a certificate to an entity that is certified and a letter of registration to an entity that is registered.

Section 19.1704(f) and §19.2004(f) change the requirements in existing §19.1704(e)(2) and §19.2004(e)(2) by lessening the number of days that an applicant has to correct any omissions or deficiencies in the application from 30 days to 15 working days from the date of TDI's latest notice of the omissions or deficiencies. This reduction in time is necessary to streamline the application process, providing TDI with information more quickly. This increased efficiency will make URAs more quickly available to the Texas consumer. Section 19.1704(f) and §19.2004(f) also provide that the applicant may request in writing additional time to correct the omissions or deficiencies in the application, and that the request for the additional time must be approved by TDI in writing for the requested extension to be effective.

Section 19.1704(g) and §19.2004(g) provide that each active certification or registration expires two years after the date of issuance.

Section 19.1704(h) and §19.2004(h) clarify that the two-year renewal requirement applies to both certifications and registrations, the process of submitting a URA application to TDI, and the fees for renewal of a certification. Insurance Code §4201.103 provides that certification may be renewed biennially by filing with the commissioner, not later than March 1, a renewal form accompanied by a fee in an amount set by the commissioner. Insurance Code §4201.104(a) authorizes the commissioner to promulgate forms to be filed for a renewal certificate of registration.

Section 19.1704(h)(1) and §19.2004(h)(1), (relating to continued operation during TDI review), provides that a URA may continue to operate under its certification or registration until the renewal application is denied or issued by TDI if a URA meets two requirements. The URA must have sent to TDI, on or before the expiration of its certification or registration, the information specified in subsection (h); and the URA must have submitted the fee required for certification renewal, if applicable.

Section 19.1704(h)(2) and §19.2004(h)(2) specify the requirements for renewal if the certification or registration has been expired for 90 days or less. Under §19.1704(h)(2) and §19.2004(h)(2), the URA may renew the certification or registration by filing a completed renewal application, the fee as applicable for certification renewal, and the required information described in subsection (h). Section 19.1704(h)(2) and §19.2004(h)(2) prohibit the URA from operating from the time the certification or registration has expired until the time TDI grants the URA a renewal certification or registration.

Section 19.1704(h)(3) and §19.2004(h)(3) specify the requirements if the certification or registration has been expired for longer than 90 days. The URA may not renew the certification or registration but must obtain a new certification or registration by submitting an application for original issuance of the certification

or registration and an original application fee as applicable for certification in accord with §19.1704 or §19.2004.

Section 19.1704(i) and §19.2004(i), regarding contesting a denial of an application or renewal, track existing §19.1704(g) and §19.2004(h) with nonsubstantive clarifications.

Section 19.1704(j) and §19.2004(j) describe an existing URA's obligation to update its application within 90 calendar days after the effective date of the rule. However, the submission of an updated application does not change the URA's existing renewal date, and subsection (h) of this section still governs the URA's renewal process.

Section 19.1705 and §19.2005 address General Standards of Utilization Review. The components listed in existing §19.1705(1) - (3) and §19.2005(1) - (3) to be included in the utilization review plan are not included in the new sections because TDI adopts updated required components in subsections (b) - (f) of §19.1705 and §19.2005 or the components are otherwise incorporated into other sections, and the retention of the provisions would be repetitive.

Section 19.1705(a) and §19.2005(a) require that the utilization review plan be approved by a physician; periodically updated; and include input from both primary and specialty physicians, doctors, or other health care providers, in accord with Insurance Code §4201.151.

Section 19.1705(b) and §19.2005(b) add a statutorily required general standard of utilization review relating to special circumstances. It requires the utilization review determination to take into account special circumstances of each case that may require deviation from the norm stated in the screening criteria or relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness. This requirement is consistent with Insurance Code §4201.153.

Section 19.2005(b) also provides that for purposes of new §19.2005, disability must not be construed to mean an injured employee who is off work or receiving income benefits. This provision is included to further clarify the scope of special circumstances. In establishing general standards for utilization review, the language in §19.2005(b) distinguishes the term "disability" as it is used in general medical environments from how the term is used in the Texas workers' compensation system. The term "disability" as used in this section should not be confused with the Texas Workers' Compensation Act's definition of "disability." Labor Code §401.011(16) defines "disability" as "the inability because of a compensable injury to obtain and retain employment at wages equivalent to the pre-injury wage."

Section 19.1705(c) and §19.2005(c) add screening criteria provisions. The sections describe the requirements for screening criteria, requiring that they be evidence-based, scientifically valid, outcome-focused, and compliant with Insurance Code §4201.153. Insurance Code §4201.153(a) - (c) requires that a URA use written medically acceptable screening criteria and review procedures that are established, periodically evaluated, and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers. It further requires that a utilization review determination be made in accord with currently accepted medical or health care practices, taking into account special circumstances of the case that may require deviation from the norm stated in the screening criteria. The screening criteria must be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow a deviation from the norm when justified on a case-by-case basis.

Additionally, §19.1705(c) and §19.2005(c) require screening criteria to recognize that the URA must use generally accepted standards of medical practice recognized in the medical community if evidence-based medicine is not available for a particular health care service provided. This provision is necessary because evidence-based medicine is not always available. This provision also harmonizes the Subchapter R screening criteria requirements with Subchapter U screening criteria requirements. Section 19.2005(c) also incorporates requirements of Labor Code §401.011(22-a) and is necessary because evidence-based medicine is not always available. Insurance Code §4201.054(c) states that Labor Code Title 5 prevails in the event of a conflict between Insurance Code Chapter 4201 and Labor Code Title 5. TDI determined this conforming change is necessary in the Subchapter R rules to implement the existing requirements for screening criteria in accord with §4201.153 while maintaining screening criteria standards that are consistent with the screening criteria standards under Subchapter U. This requirement is adopted under the commissioner's rulemaking authority in Insurance Code §4201.003 to adopt rules to implement Insurance Code Chapter 4201.

Section 19.1705(d) and §19.2005(d) require that adverse determinations be referred to and determined by an appropriate physician, doctor, or other health care provider. This requirement implements the expanded scope of adverse determinations under HB 4290. The requirement in §19.1705(d) and §19.2005(d) is consistent with Insurance Code §4201.153(d) and existing §19.1705(a)(3). Existing §19.1705(a)(3) already allowed a health care provider to make adverse determination decisions. New §19.2005(d) also requires that physicians and doctors performing utilization review comply with Labor Code §§408.0043 - 408.0045. References to these Labor Code provisions are necessary to ensure that physicians and doctors meet these professional certification requirements for conducting utilization review.

Section 19.1705(e) and §19.2005(e) permit a URA to delegate utilization review to qualified personnel in a hospital or other health care facility in which the health care services to be reviewed were, or are, to be provided. These sections are consistent with Insurance Code §4201.251, regarding delegation of utilization review.

Section 19.1705(f) and §19.2005(f) require the URA to develop and implement procedures for the resolution of oral or written complaints concerning utilization review. These requirements are consistent with Insurance Code §4201.204. Additionally, the sections add a new requirement that the written response include TDI's address, toll-free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI. This information is necessary to inform the consumer of the right to file a complaint and the means by which the consumer may contact TDI.

Section 19.2005(g) requires utilization review plan written policies to evidence compliance with Labor Code §504.055. This adopted subsection corresponds with the requirements of Labor Code §504.055(c), which states that, "The political subdivision, division, and insurance carrier shall accelerate and give priority to an injured first responder's claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury described by Subsection

(b)." Labor Code §504.055(b) provides, in part, that, "This section applies only to a first responder who sustains a serious bodily injury, as defined by Section 1.07, Penal Code, in the course and scope of employment."

Section 19.1706 and §19.2006 address Requirements and Prohibitions Relating to Personnel. Section 19.1706(a) and §19.2006(a) require all health care providers employed or contracted with the URA to perform utilization review to be appropriately trained, qualified, and currently licensed. This requirement is more stringent than the requirement in existing §19.1704(h)(1) and §19.2004(f)(1), which only requires that the URA have available the qualified medical personnel to provide the services requested. However, this more stringent requirement incorporates the existing requirement under §19.1706 and §19.2006 that personnel employed by or contracted with the URA to perform utilization review be appropriately trained, qualified, and, if applicable, currently licensed. The additional criteria will ensure that utilization review is conducted by appropriate individuals and should ensure a higher quality of utilization review.

Section 19.1706(a) and §19.2006(a) also require personnel conducting utilization review to hold an unrestricted license, administrative license, or to be otherwise authorized to provide health care by a licensing agency in the United States, or in Texas, respectively. These new sections were unanimously recommended by the Utilization Review Advisory Committee and are consistent with Insurance Code §4201.252(a), which requires personnel employed by or contracted with a URA to perform utilization review to be appropriately trained and qualified.

Section 19.1706(a)(1) and §19.2006(a)(1) clarify that the adopted rules do not supersede requirements in the Medical Practice Act, Texas Medical Board rules, Texas Occupations Code Chapter 201 (relating to Chiropractors), or Texas Board of Chiropractic Examiners rules. Section 19.1706(a)(2) and §19.2006(a)(2) clarify that personnel who perform clerical or administrative tasks are not required to have the qualifications of personnel conducting utilization review, which is consistent with Insurance Code §4201.051.

Section 19.1706(b) and §19.2006(b) prohibit a physician, doctor, or other health care provider who conducts utilization review from having any disqualifying associations with the physician, doctor, or other health care provider who issued the initial adverse determination. Section 19.1706(b) and §19.2006(b) also prohibit a physician, doctor, or other health care provider who conducts utilization review from having any disqualifying associations with the enrollee, or the injured employee, respectively, or health care provider who is requesting the utilization review or an appeal. The subsections also clarify that being employed by or contracted with the same URA as the physician, doctor, or other health care provider who issued the initial adverse determination does not in itself constitute a disqualifying association; however, another disqualifying association may apply.

Section 19.1706(c) and §19.2006(c) require that the URA provide to TDI information and qualifications of the personnel employed or contracted to perform the utilization review on filing an original or renewal application. This information is important because it allows TDI to monitor the credentials of staff performing utilization review. To avoid unnecessary administrative burdens, TDI clarifies that URAs do not have to provide information on any administrative staff who is not conducting utilization review.

Section 19.2006(c) requires all personnel performing utilization review of workers' compensation services to be licensed in Texas or be otherwise authorized to provide health care services in Texas. This requirement is consistent with the objectives of Labor Code §408.023(h) and HB 1006, 80th Legislature, Regular Session, effective September 1, 2007, and is necessary to ensure that appropriate health care providers, in accord with Insurance Code §4201.153(d), are used to determine medical necessity.

Section 19.1706(d) and §19.2006(d) require URAs to develop and implement written procedures to determine if physicians, doctors, and other health care providers used by the URA are licensed, qualified, and appropriately trained or experienced.

Section 19.2006(e) requires utilization review conducted by a URA to be under the direction of a physician currently licensed without restriction to practice medicine. This section implements Insurance Code §1305.351 and Labor Code §408.023(h), which provide that only doctors licensed to practice in this state may perform utilization review. The requirement that the physician be licensed without restriction will ensure that utilization review is conducted by appropriately trained and qualified individuals and ensure a higher quality of utilization review.

Section 19.1706(e) requires the URA to provide adequate training to personnel responsible for precertification, certification, and recertification of services or treatment related to acquired brain injury treatment, consistent with Insurance Code §1352.004. Section 1352.004 provides that "preauthorization" means the provision of a reliable representation to a physician or health care provider of whether a health benefit plan issuer will pay the physician or provider for proposed medical or health care services. The term includes precertification, certification, recertification, or any other activity that involves providing a reliable representation by the issuer to a physician or health care provider. Under Insurance Code §1352.004, the commissioner adopted 28 TAC §21.3104 to require that a health benefit plan issuer provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan.

The purpose of the training is to prevent denial of coverage in violation of §1352.003 and to avoid confusion of medical benefits with mental health benefits. Although Insurance Code §1352.004 specifies that a health benefit plan issuer must provide this training and is silent concerning a URA, new §19.1706(e) will ensure that URA personnel will receive adequate training, consistent with the plain language of §1352.004 requiring training for personnel responsible for utilization review under the plan. The requirement that URA personnel receive the training is adopted under the commissioner's rulemaking authority in Insurance Code §4201.003 to adopt rules to implement Chapter 4201 and under Insurance Code §1352.004(b).

Section 19.1707 and §19.2007 address URA Contact With and Receipt of Information from Health Care Providers.

Section 19.1707(a) and §19.2007(a) clarify existing §19.1708(b) and §19.2008(b) requirements affecting the health care provider's charge for providing medical information by providing a specific citation to 28 TAC §134.120 (relating to Reimbursement for Medical Documentation). This clarification is necessary for purposes of readability and ease of compliance. Also, because there are no existing relevant TDI-DWC rules or guidelines specifying costs that may not be reimbursed separately, new §19.2007(a) also deletes the existing prohibition against inclusion of costs that may not be reimbursed separately in

a health care provider's charge for providing medical information. Section 19.2007(a) also provides that a health care provider must submit required documentation to the URA when submitting a medical bill under 28 TAC Chapter 133. Under existing rules, the URA was already required to request the information necessary to complete the review and could only request information relevant to the review.

The reimbursement requirement in §19.2007(a) for workers' compensation utilization review mirrors the reimbursement requirement for URAs in §19.1707(a) of these rules and applies to requests for medical information related to all types of utilization review, including concurrent and retrospective review. This alignment is necessary to ensure consistent regulation of URAs and to prevent confusion for URAs that are certified for both health and workers' compensation.

In terms of prospective and concurrent utilization review, existing rules in Chapter 10 (for network care) and Chapter 134 (for non-network care) clarify that a health care provider submitting a request for health care services must include information to substantiate the medical necessity of the services requested. In terms of retrospective utilization review, existing rules in Chapter 133, which apply to both network and non-network care, clarify when medical information must be submitted and the types of information that must be submitted along with a medical bill for health care services that have already been rendered. Thus, the health care provider is bearing some of the cost.

An insurance carrier may already have provided written medical information that is later being requested by the URA. In that case, it is the insurance carrier's obligation to supply the URA with whatever medical information it may already have to avoid unnecessary requests for information from the health care provider. However, if the insurance carrier is not able to provide this information to the URA or does not have this information, and the URA has determined that the information is necessary to conduct utilization review, then the URA, with whatever financial arrangements the URA has with the insurance carrier, is expected to reimburse the health care provider for the requested written medical information. It is in the requesting provider's interest to provide the relevant information to avoid a denial based on lack of the necessary documentation.

Adopted §19.1707(b) and §19.2007(b) require the URA conducting utilization review to request "all relevant and updated medical records" to complete the review. This ensures that the URA uses the most recent and complete information possible to review the treatment of the enrollee or injured employee, respectively. Although treatment may vary on a case-by-case basis, TDI determined that this requirement will enable the most effective review. Existing text under §19.1708(c) stated, "These items shall only be requested when relevant to the utilization review in question and be requested as appropriate from the beneficiary, plan sponsor, health care provider, or health care facility." Thus, existing regulations already required that requested items be relevant to the utilization review.

Section 19.1707(b)(1) and §19.2007(b)(1) permit the URA to request records necessary to conduct the utilization review even if those records contain identifying information about the claim and about the treating physician, doctor, or other health care provider. This information clarifies the scope of medical records that the URA may request to ensure that the URA has all relevant and updated medical records needed to complete the review. Information about the doctor is included as part of the medical record.

Section 19.1707(b)(2) and §19.2007(b)(2) prohibit a URA from routinely requesting copies of all medical records. These sections are designed to allow the URA to seek the information necessary for the review on a case-by-case basis without routinely requesting an entire medical record. These sections mirror existing requirements in §19.1708(b)(2) and §19.2008(c)(2). The intent of the new sections is to require the URA to evaluate what records are needed. Section 19.1708(b) and §19.2008(b) do not require an overly broad request that would result in the transmission of unnecessary information. A balance in the amount of information requested will result in more efficient review, because of the relevance of the provided documents and the reduced cost. Even though the requesting party must submit information to support the request, the URA should request missing information necessary to conduct the review.

Section 19.1707(c) and §19.2007(c) mirror the requirements in existing §19.1708(e) and §19.2008(e).

Section 19.1707(d) and §19.2007(d) add the modifying phrase "that relate to the mental health therapist's treatment of an injured employee's mental or emotional condition or disorder" to the prohibition in existing §19.1708(f) and §19.2008(f), and further describe the process or progress notes that are contemplated. The sections also provide that the prohibition extends to requiring an oral, electronic, facsimile, or written submission or rendition of a mental health therapist's process or progress notes.

Section 19.1707(d)(1) and §19.2007(d)(1) provide that this prohibition does not preclude the URA from requiring submission of an injured employee's mental health medical record summary. Section 19.1707(d)(2) and §19.2007(d)(2) provide that the prohibition does not preclude the URA from requiring submission of medical records or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder. The consistency between the Subchapter R and Subchapter U adopted rules is necessary because the rules are based on the same underlying statute. Insurance Code §4201.203(a) prohibits a URA from requiring the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes, as a condition of treatment approval or for any other reason. Section 4201.203(b) clarifies that a URA may nonetheless require submission of a patient's medical record summary.

Section 19.1708 and §19.2008 address On-Site Review by the URA. Section 19.1708(a) and §19.2008(a) require URA staff members to identify themselves by name, organization, photo identification, and the URA's identification card with TDI's assigned certificate number. This requirement applies at all times while the members are engaged in utilization review and not just during "on-site reviews." This requirement is intended to ensure that all parties involved are aware that the URA is conducting the utilization review and are able to confirm the identity of the URA staff members who are engaged in utilization review.

Section 19.1708(b) and §19.2008(b), relating to on-site review at a health care facility, change the references in existing §19.1709(b) and §19.2009(b), from hospital to a "health care facility." The broader term "health care facility" includes a hospital, emergency clinic, outpatient clinic, or other facility providing health care and is necessary for clarification and accuracy.

Section 19.1709 and §19.2009 address Notice of Determinations Made in Utilization Review. Section 19.2009(a) addresses requirements for both favorable and adverse determination no-

tices. Section 19.1709(a) and §19.2009(a)(1) track the requirements in Insurance Code §4201.301.

To clarify distinctions between requirements within the sections that apply to prospective and concurrent review, versus retrospective review, the sections are formatted so that §19.2009(a)(2) and §19.1709(d) apply to prospective and concurrent review, and §19.2009(a)(3) and §19.1709(e) apply to retrospective review. Section 19.2009(a)(2) and §19.1709(d)(3) specify required timeframes for notification of an adverse determination for consistency with Insurance Code §4201.304. Section 19.1709(d)(3) also adds clarifying language that the denial of post-stabilization care subsequent to emergency treatment must be followed by a written notification within three working days of the telephone or electronic transmission. These rules do not repeat the rest of the requirements under Insurance Code §4201.304 because no other clarifying changes were made. Section 19.1709(d)(1) tracks the requirements in Insurance Code §4201.302.

Section 19.2009(a)(2)(A) and §19.2009(a)(2)(B) specify required timeframes for notification of a prospective or concurrent utilization review adverse determination and adopt timeframe requirements to be consistent with 28 TAC §134.600 for workers' compensation non-network coverage, or with Insurance Code §1305.353 and 28 TAC §10.102 for workers' compensation network coverage, respectively.

Section 19.2009(a)(3)(A) and (B) require the notice of a retrospective adverse determination to be provided within the timeframes specified by TDI-DWC rules in 28 TAC Chapter 133 (relating to General Medical Provisions) for workers' compensation non-network coverage, and TDI rules in 28 TAC Chapter 10 (relating to Workers' Compensation Health Care Networks) and TDI-DWC rules in 28 TAC Chapter 133 for workers' compensation network coverage, respectively. These provisions are consistent with Insurance Code §4201.305.

Section 19.1709(b) and §19.2009(b) clarify that the subsections regulate the information that must be included in notices of prospective, concurrent, or retrospective utilization review adverse determinations. With the exception of §19.1709(b)(4) and §19.2009(b)(4), all of the information that must be included in all notices of adverse determinations in §19.1709(b) and §19.2009(b) are required by Insurance Code §4201.303(a). TDI added one notice element to the list in §4201.303(a). Insurance Code §1305.353(b) states, "Notification of an adverse determination must include" certain elements and §4201.303(a) states, "Notice of an adverse determination must include" certain elements. These lead-in sentences indicate that TDI does not have authority to exclude one of these statutory requirements, but these statutes do not limit the elements in the notice to only those elements. This adoption order includes all of the statutory elements and adds to the notice requirements under Insurance Code §4201.003, which grants rulemaking authority to implement Insurance Code Chapter 4201.

Section 19.1709(b)(4) and §19.2009(b)(4) require notice of the professional specialty of the physician, doctor, or other health care provider who made the adverse determination. Section 19.2009(b)(4) also requires notice of the Texas license number of the physician, doctor, or other health care provider that made the adverse determination.

TDI determined that the additional notice element in §19.1709(b)(4) and §19.2009(b)(4) is necessary to provide important consumer information to the enrollee, or injured employee, respectively, and the provider of record should the adverse determination be appealed. Specifically, this information is necessary for the consumer's understanding of the professional background and training of that physician, doctor, or other health care provider. The information that would be provided under the adopted new notice element may also assist the provider of record in assessing whether the enrollee or injured employee, respectively, might benefit from requesting a physician or doctor of a particular specialty; other than the specialty of the physician, doctor, or other health care provider that made the adverse determination; if an appeal of the adverse determination is filed.

Section 19.1709(b)(5) - (9) and §19.2009(b)(3), (5), (6), and (9) are consistent with Insurance Code §4201.303(a)(4) and §4201.303(b). The requirement in §19.1709(b) and §19.2009(b), regarding the provision of information on the URA appeal process and notice of the independent review process, along with a copy of the request for a review by an IRO form, will inform the enrollee, or injured employee, respectively, of available options following an adverse determination. The information will also inform the provider of record of what information is necessary for the appeal of an adverse determination. The release of information to an IRO must also comply with Insurance Code §4201.552, which prohibits a URA from disclosing individual medical records, personal information, or other confidential information about a patient obtained in the performance of utilization review without the patient's prior written consent or except as otherwise required by law. Section 4201.552 also requires that if the prior written consent is submitted by anyone other than the patient who is the subject of the personal or confidential information requested, the consent must be dated and contain the patient's signature.

Section 19.1709(c) specifies the requirements relating to a notice of determination concerning an acquired brain injury. A URA must comply with the notice requirements relating to notification of favorable determinations and relating to notice of adverse determinations. Additionally, in regard to a determination concerning an acquired brain injury as defined by 28 TAC §21.3102, not later than three business days after the date on which an individual requests utilization review or an extension of coverage that is based on medical necessity or appropriateness, the URA must notify the requestor of the determination through a direct telephone contact. Section 19.1709(c) also provides that the subsection does not apply to a determination made for coverage under a small employer health benefit plan, consistent with Insurance Code §1352.006.

Section 19.2009(c) clarifies that the URA may consolidate the notice of an adverse determination and the peer review report into one document if the document contains all the notice elements required under both §19.2009(c) and 28 TAC §180.28.

Section 19.1709(d)(2) and §19.2009(a)(4) require a URA to ensure that the preauthorization numbers it assigns comply with the data and format requirements contained in the standards adopted by the U.S. Department of Health and Human Services in 45 C.F.R. §162.1102. These standards apply under federal law to health insurers and HMOs and already apply to health insurers and HMOs conducting utilization review. For consistency among all URAs, TDI determined it is necessary to require preauthorization numbers issued by all URAs to comply with the federal data and format requirements. This requirement will prevent different numbering systems based on whether the URA is subject to the federal regulations.

Section 19.1709(e)(1) requires the notice of a retrospective adverse determination to be provided within the timeframes specified by Insurance Code §4201.305 and §19.1709(e). Section 19.1709(e)(2) tracks Insurance Code §4201.203.

Section 19.1710 and §19.2010 address Requirements Prior to Issuing Adverse Determination. Section 19.1710 and §19.2010 address requirements regarding any instance in which the URA is questioning health care services on the basis of medical necessity or appropriateness, or on the basis of the experimental or investigational nature of the services under §19.1710, prior to issuing a utilization review adverse determination. The URA must afford the provider of record a reasonable opportunity, as defined in §19.1703(b)(28) and §19.2003(30), to discuss the plan of treatment with a physician.

Section 19.1710 and §19.2010 require that the discussion include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record, that, on appeal, might lead to a different utilization review decision, in addition to the discussion of the plan of treatment for the enrollee. By specifying minimum elements, the adopted rules clarify that the required discussion may also include other matters as deemed necessary by the URA or provider of record.

Section 19.1710(1) and §19.2010(1) specify that when the URA provides the reasonable opportunity required under §19.1710 or §19.2010, respectively, the URA must include the URA's phone number so that the provider of record may contact the URA to discuss the pending adverse determination.

Section 19.1710(2) and §19.2010(2) require the URA to maintain documentation detailing the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination; the date and time that the discussion, if any, took place; and the outcome. Section 19.1710(2) and §19.2010(2) also require that the URA submit this required documentation to TDI, or TDI-DWC, respectively, on request. These requirements are necessary to enable TDI to monitor whether a reasonable opportunity for discussion was offered and to collect information on peer-to-peer discussion results. This information will assist TDI in ensuring compliance with the requirement that URAs provide a reasonable opportunity for discussion with the provider of record prior to issuing the adverse determination and in determining the effectiveness of the peer-to-peer discussions.

These requirements to offer an opportunity to discuss the treatment prior to issuance of a retrospective review adverse determination implement statutory requirements resulting from the expanded definition of "utilization review" under HB 4290 to specifically incorporate "retrospective review." Insurance Code §4201.206 provides that, subject to the notice requirements of Chapter 4201, Subchapter G, and before an adverse determination is issued by a URA, the URA must provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination.

Because in pertinent part Insurance Code §4201.002 defines a "utilization review agent" as "an entity that conducts utilization review" and the term "utilization review" includes "retrospective review" under Insurance Code §4201.002(13), the §4201.206 requirement for a reasonable opportunity discussion applies to a URA conducting retrospective review.

Section 19.1711 and §19.2011 address Written Procedures for Appeal of Adverse Determinations. Section 19.1711(a) and §19.2011(a) govern appeal of prospective or concurrent adverse determinations. The sections require each URA to comply with its written procedures for appeals and require a URA's written procedures for appeals to comply with insurance Code Chapter 4201, Subchapter H.

Section 19.1711(a)(1) requires these procedures to include a statement specifying the timeframes for filing the written or oral appeal, which may not be less than 30 days after the issuance of written notification of an adverse determination. This 30-day provision allows the enrollee adequate time to appeal an adverse determination and specifies a uniform minimum time for all enrollees to submit an appeal.

Section 19.2011(a)(1) addresses the timeframes for filing the appeal for workers' compensation network coverage. It requires the URA's written procedures for appeals to include a statement specifying the timeframes for filing the oral or written appeal in accord with Insurance Code §1305.354, which may not be less than 30 days after the issuance of written notification of an adverse determination. This 30-day provision allows the injured employee adequate time to appeal the adverse determination and is consistent with 28 TAC §10.103 (relating to Reconsideration of Adverse Determination).

Under §19.1711(a)(1) and §19.2011(a)(1), all enrollees, or injured employees, respectively, will have at least 30 days to appeal an adverse determination, regardless of which URA handled the utilization review. These provisions are also consistent with Insurance Code §4201.353, which provides that the procedures for appealing an adverse determination must be reasonable.

Section 19.2011(a)(2) addresses the timeframes for filing the appeal for workers' compensation non-network coverage and workers' compensation health plan. It requires the URA's written procedures for appeals to include a statement specifying that the timeframes for filing the oral or written appeal must comply with 28 TAC §134.600 (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) and 28 TAC Chapter 133, Subchapter D (relating to Dispute of Medical Bills).

Section 19.1711(a)(2) and §19.2011(a)(3) require the URA's written procedures for appeals to include a provision that an enrollee or injured employee, respectively; their representative; or the provider of record may appeal the adverse determination by making an oral or written request. This requirement is consistent with Insurance Code §4201.354.

Section 19.1711(a)(3)(A) - (D) maintains the existing requirements relating to an appeal acknowledgement letter to be sent by the URA to the appealing party.

Section 19.1711(a)(4) requires the written procedures for appeals to include a provision that an appeal decision must be made by a physician who has not previously reviewed the case. This provision is consistent with Insurance Code §4201.356(a), which provides that the procedures for appealing an adverse determination must provide that a physician makes the decision on the appeal, except as provided by §4201.356(b), relating to specialty provider reviews.

Section 19.2011(a)(4) requires the URA's written procedures for appeals to include a provision that appeal decisions must be made by a physician, dentist, or chiropractor who has not previously reviewed the case. This provision is consistent with Insur-

ance Code §4201.356(a), Insurance Code §1305.354, 28 TAC Chapter 180, and 28 TAC §10.103. This requirement provides consistency of utilization reviews for all injured employees.

Section 19.2011(a)(5) requires that in any instance in which the URA is questioning the medical necessity or appropriateness of the health care services, the URA must afford the provider of record a reasonable opportunity, as defined in §19.2003(28), to discuss the plan of treatment for the injured employee with a physician before issuing an adverse determination. The discussion must include, at a minimum, the clinical basis for the URA's decision. Denial of an appeal is an adverse determination, which would require the URA to afford the provider of record a reasonable opportunity to discuss the plan of treatment before issuing an adverse determination. This provision is consistent with Insurance Code §4201.206.

Section 19.1711(a)(5) further requires the written procedures to include a provision that in any instance in which the URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature of the health care services, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician before issuing an adverse determination. The provision must require the discussion to include, at a minimum, the clinical basis for the URA's decision.

Section 19.1711(a)(6) mirrors the requirement under Insurance Code §4201.356(b), which provides a process for requesting a particular type of specialty provider to review a case and requires the specialty review to be completed within 15 working days. Insurance Code §4201.457 governs the appeal decisions for specialty URAs.

Section 19.2011(a)(6) requires the URA's written procedures for appeals to include a provision that, after the URA has sought review of the appeal, the URA must issue a response letter explaining the resolution of the appeal to certain individuals specified on the basis of the underlying workers' compensation coverage.

Section 19.1711(a)(7) tracks the requirements in Insurance Code §4201.357. Section 19.1711(a)(7)(C) requires the written procedures for appeal to include a provision that an expedited appeal determination may be provided by telephone or electronic transmission but must be followed with a letter within three working days of the initial telephonic or electronic notification. The requirement for the follow-up letter is necessary to ensure that the appealing party receives prompt written documentation of the expedited appeal determination.

Section 19.2011(a)(7)(A) - (G) specify the elements of information that must be included in the response letter for both workers' compensation network and non-network coverage. Subparagraph (A) requires a statement of the specific medical or dental reasons for the resolution. Subparagraph (B) requires the clinical basis for the decision, including screening criteria. Subparagraph (C) requires the professional specialty and Texas license number of the physician who made the determination. Subparagraph (D) requires notice of the appealing party's right to seek review of the denied appeal by an IRO, the procedure for obtaining that review, and procedures for obtaining a copy of the request for a review by an IRO form. Subparagraph (E) states procedures for filing a complaint in accord with Insurance Code §4201.204. Subparagraph (F) requires a description of the screening criteria used in making the determination for workers' compensation network coverage, as well as a description of the network proposed treatment guidelines. Subparagraph (G) requires the URA conducting utilization review for workers' compensation non-network coverage to include a description of the treatment guidelines used in accord with 28 TAC Chapter 137 (relating to Disability Management) in making a determination. These requirements provide the injured employee with important information concerning the basis for the determination.

Section 19.1711(a)(8)(A) - (H) specify the elements of information that must be included in the response letter. Subparagraph (A) requires a statement of the specific medical, dental, or contractual reasons for the resolution, as required in existing §19.1712(b)(5)(A). Subparagraph (B) requires the clinical basis for the decision. Subparagraph (C) requires a description of, or the source of, the screening criteria used in making the determination. Subparagraph (D) requires the professional specialty of the physician who made the determination. Subparagraph (E) requires notice of the appealing party's right to seek review of the adverse determination by an IRO. Subparagraph (F) requires notice of the independent review process and the procedures for obtaining that review. Subparagraph (G) requires a copy of the request for a review by an IRO form in addition to the existing rule requirement for a notice of the appealing party's right to seek review of the denied appeal by an IRO and the procedures for obtaining that review. Subparagraph (H) requires procedures for filing a complaint in accord with Insurance Code §4201.204 and as described in §19.1705(f).

Section 19.2011(a)(8) specifies the timeframes for written notifications of the appeal determination as a required component of the response letter under the URA's procedures. These appeals must be resolved in accord with 28 TAC §10.103 for workers' compensation network coverage and 28 TAC §134.600 for workers' compensation non-network coverage.

Section 19.1711(a)(9) requires the URA's written appeal procedures to include a provision that the appeal must be resolved as soon as practical, but in accord with Insurance Code §4201.359, in no case later than 30 calendar days after the date the URA receives the appeal from the appealing party referenced in §19.1711(a)(3). TDI deleted the word "written" and the phrase "or the one-page appeal form" to more closely track the requirements under Insurance Code §4201.359.

Section 19.1711(a)(10) and §19.2011(a)(9) provide that an enrollee or injured employee, respectively, may request and is entitled to an immediate review by an IRO of an adverse determination in a circumstance involving a life-threatening condition. This provision is consistent with Insurance Code §4201.360. Section 19.2011(a)(9) also provides that in a circumstance involving a request for a medical interlocutory order under 28 TAC §134.550, the injured employee is entitled to an immediate review by an IRO of the adverse determination.

These rules implement statutory provisions of Insurance Code Chapter 4201. Insurance Code §4201.303(b) provides that, for an enrollee who has a life-threatening condition, the notice of an adverse determination must include a description of the enrollee's right to an immediate review by an IRO and of the procedures to obtain that review. Insurance Code §4201.360 provides that, notwithstanding any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an IRO and is not required to comply with procedures for an internal review of the URA's adverse determination.

The terms "life-threatening" and "medical emergency" overlap but are not synonymous. The term "life-threatening," under

Insurance Code §4201.002(7), is a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. There is no requirement that the likelihood of death is imminent or the condition is acute. The terms "emergency care," under Insurance Code §4201.002(2), and "medical emergency," under Insurance Code §1305.004(13), both require the condition to be of recent or sudden onset, respectively, and require immediate medical care or attention, in part, to avoid placing the individual's health in serious jeopardy. Section 19.2003(18) also contains a separate definition of "medical emergency" that tracks the definition in Insurance Code §1305.004(13) with a clarifying change from the use of the term "patient" to the term "injured employee."

Additionally, Labor Code §413.014, Insurance Code §1305.351, and 28 TAC §134.600 exempt emergency treatment and services from prospective and concurrent utilization review, but it is not TDI's intent to apply the requirements regarding life-threatening conditions to emergency treatment.

Section 19.1711(b) and §19.2011(b) govern appeals of retrospective adverse determinations and require the URA to maintain and make available a written description of these appeal procedures. Section 19.2011(b) requires that these appeals comply with §19.2009.

Section 19.1711(b)(1) requires the appeal procedures to comply with the requirements in 28 TAC Chapter 21, Subchapter T (relating to Submission of Clean Claims), if applicable, because not all entities subject to Subchapter R may be subject to 28 TAC Chapter 21, Subchapter T. Section 19.1711(b)(2) requires that these appeals comply with §19.1709.

Section 19.2011(b)(1) requires workers' compensation network coverage appeal procedures to comply with the requirements in Insurance Code Chapter 1305 and 28 TAC Chapters 10 and 133. This subsection clarifies that for claims under network coverage these requirements are to be applied in tandem with TDI's rules concerning workers' compensation health care networks and also with TDI-DWC's rules concerning general medical procedures.

Section 19.2011(b)(2) requires a URA's workers' compensation non-network coverage appeal procedure to comply with the requirements of 28 TAC Chapter 133. This provision clarifies that these adopted rules do not exempt insurance carriers from TDI-DWC's medical billing rules or otherwise modify their duties under those rules.

Section 19.1711(c) addresses appeals of adverse determinations concerning acquired brain injuries. A URA must make a determination concerning an acquired brain injury no later than three business days after the date an individual requests utilization review or an extension of coverage based on medical necessity or appropriateness. The URA must provide notification of the determination through a direct telephone contact to the requestor. This provision is consistent with Insurance Code §1352.006.

Section 19.1712 addresses URA's Telephone Access, and §19.2012 addresses URA's Telephone Access and Procedures for Certain Drug Requests and Post-Stabilization Care. Section 19.1712(a) and §19.2012(a) track Insurance Code §4201.004, and clarify that a URA must have appropriate personnel reasonably available by toll-free telephone at least 40 hours per week during normal business hours in both Central Time and Mountain Time. The clarifying phrase "Central Time and Mountain Time" is necessary because Texas includes both time zones, and the location of the URA should not pose a barrier to care.

Section 19.1712(b) clarifies that the section does not apply to an HMO or preferred provider benefit plan that is subject to §19.1718 or §19.1719. This exemption is necessary because §19.1718 and §19.1719 specify detailed telephone access requirements for HMOs or preferred provider benefit plans, respectively.

Section 19.2012(b) requires a URA to have and implement procedures when responding to two types of requests. The procedures must address requests for drugs that require preauthorization if the injured employee has received or is currently receiving the requested drugs and an adverse determination could lead to a medical emergency. They also must address requests for post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment, as requested by a treating physician or provider of record.

The requirement in §19.2012(b) is necessary to complement the pharmacy closed formulary rules in 28 TAC Chapter 134, Subchapter F, for both certified network and non-network claims in workers' compensation. Section 134.550 provides a prescribing doctor or pharmacy the ability to obtain a medical interlocutory order in certain instances in which preauthorization denials of a previously prescribed and dispensed drug excluded from the closed formulary pose an unreasonable risk of a medical emergency as defined in 28 TAC §134.500(7) and Insurance Code §1305.004(a)(13). Subchapter R rules do not have an equivalent requirement because the pharmacy closed formulary rules do not apply to health care provided under a health benefit plan or health insurance policy. The purpose of new §19.2012(b) is to require the URA to have specific procedures for high-risk situations.

Section 19.1713 and §19.2013 address Confidentiality. Section 19.1713(a) and §19.2013(a) require a URA to provide its certification number, name, and professional qualifications when contacting a physician's, doctor's, or other health care provider's office. Section 19.1713(a)(1) and §19.2013(a)(1) require the URA to present written documentation that the URA is acting as an agent of the payor or insurance carrier, respectively, for the relevant enrollee or injured employee, respectively. These requirements are consistent with Insurance Code §4201.551(a).

Section 19.1713(a)(2) and §19.2013(a)(2) clarify that the duty to retain the information rests with the URA and are consistent with Insurance Code §4201.557, which states, "A utilization review agent shall maintain all data concerning a patient or physician or other health care provider in a confidential manner that prevents unauthorized disclosure to a third party."

Section 19.1713(a)(3) and §19.2013(a)(3) make the requirement that information be retained for "at least two years if the information relates to a case for which an adverse decision was made at any point or if the information relates to a case which may be reopened" in existing §19.1714(m) and §19.2014(m), respectively, obsolete. Section 19.1713(a)(3) and §19.2013(a)(2) require the information to be retained for at least four years and broadens the scope of information that the URA must retain to include all information generated and obtained by a URA in the course of utilization review and not just that information relating to cases for which an adverse decision was made or information relating to a case that may be reopened.

TDI determined that an increased timeframe for retaining all information generated and obtained by a URA in the course of

utilization review is necessary to address any potential issues that might arise in an appeal, including judicial review of an approval or adverse determination. The information retained may be necessary for the appeal process, which could take longer than two years. In addition, the four year retention requirement is consistent with confidentiality requirements for IROs under 28 TAC §12.208(h).

The longer retention period allows sufficient time for TDI to examine the information. TDI generally conducts URA examinations triennially, but does not always examine each URA exactly every three years. The requirement that the URA maintain information for four years will ensure that TDI has the opportunity to review the information.

Section 19.1713(a)(4) and §19.2013(a)(4) track the limitation on a URA's charges for providing a copy of recorded personal information to individuals in existing §19.1714(e) and §19.2014(e).

Section 19.1713(b) and §19.2013(b) clarify that the confidentiality requirements pertain to both: (1) the information received by the URA from the enrollee or injured employee, respectively; their representative; or the physician, doctor, or other health care provider; and (2) the information exchanged between the URA and third parties. Section 19.1713(b) and §19.2013(b) address a URA's procedures for specific information exchanged for conducting reviews. Section 19.1713(b) and §19.2013(b) incorporate the requirements in existing §19.1714(k) and §19.2014(k) and restructure the requirements for ease of readability.

Section 19.1714 and §19.2014 address Regulatory Requirements Subsequent to Certification or Registration. TDI determined that the requirements in existing §19.1716(a) and §19.2016(a) are not necessary because they repeat the requirements in Insurance Code §4201.204.

Section 19.1714(a) and §19.2014(a) require that information related to complaints be included in the summary report submitted to TDI by March 1 of each year, which tracks existing §19.1716(b) and §19.2016(b). Section 19.1714(a) and §19.2014(a) also broaden the types of information that the URA must provide in the summary report to include information related to adverse determinations and appeals of adverse determinations. These sections are authorized under Insurance Code §4201.204(c) and Insurance Code §38.001.

Section 19.1714(b) and §19.2014(b) track the requirement in the last sentence in existing §19.1716(b) and §19.2016(c). Section 19.1714(b)(1) and §19.2014(b)(1) mirror the requirements in existing §19.1716(b)(1) and §19.2016(c)(1). Section 19.1714(b)(2) and §19.2014(b)(2) mirror the requirements in existing §19.1716(b)(2) and §19.2016(c)(2) and clarify that "successor codes and modifiers" are applicable as part of the requirement to include a listing of appeals of adverse determinations by the medical condition that is the source of the dispute in the summary report submitted to TDI. The requirements in existing §19.1716(b)(4) are not included in the adopted rules because appeals of adverse determinations are not classified by the categories of "benefit denial," "timely determinations," or "screening criteria." TDI does not collect that information, and the requirements are unnecessary.

Section 19.1714(b)(3) and §19.2014(b)(3) track the requirements in existing §19.1716(b)(3) and §19.2016(c)(3), respectively. Section 19.1714(b)(4) and §19.2014(b)(4) track the requirements in existing §19.1716(b)(5), with a clarifying change from the phrase "at each level of the notification and appeal process" to the phrase "at each level within the internal utilization review process." This change clarifies that the summary does not need to include the outcomes for an IRO, contested case hearing, or judicial review. Section 19.1714(b)(5) and §19.2014(b)(5) track the requirements in existing §19.1716(b)(6).

Section 19.1714(c)(1) - (3) and §19.2014(c)(1) - (3) track the requirements in existing §19.1716(b)(6)(A) - (C) and existing §19.2016(b)(1) - (3). TDI determined that the more detailed complaint procedure requirements in existing §19.1716(c)(1) - (5) and existing §19.2016(d)(1) - (4) are not necessary because they are too restrictive and inconsistent with procedures that TDI follows for investigating and resolving other types of complaints. Those requirements are not included in the new rules, and supporting requirements in existing §19.1716(d) and existing §19.2016(e) are also deleted.

Section 19.1714(d) and §19.2014(d) provide that TDI must process complaints received against a URA under TDI's established procedures for investigation and resolution of complaints. These sections are authorized under Insurance Code §4201.003(a) and Insurance Code §36.001.

Section 19.1714(e) and §19.2014(e) reiterate TDI's authority in Insurance Code §38.001 to address inquiries to a URA, related to any matter connected with the URA's transactions, that TDI considers necessary for the public good or for the proper discharge of TDI's duties. Under Insurance Code §38.001, a URA must respond in writing to an inquiry not later than the 10th day after receipt of the inquiry.

Section 19.2014(f) clarifies that Subchapter U does not limit the ability of the commissioner of workers' compensation or TDI-DWC to make inquiries, conduct audits, or receive and investigate complaints against URAs or personnel employed by or contracted with URAs to perform utilization review to determine compliance with or violations of Labor Code Title 5 or applicable TDI-DWC rules. This provision is necessary to clarify that the investigative authority of the commissioner of workers' compensation or TDI-DWC is not limited to the authority stated in Subchapter U.

Section 19.1714(f) and §19.2014(g) contain the same requirements that are in existing §19.1716(g) and §19.2016(h) and clarify that an on-site review by TDI may be scheduled or unscheduled. Under §19.1714(f) and §19.2014(g), an on-site review will only take place during working days and normal business hours. Section 19.1714(f) and §19.2014(g) incorporate the existing provisions in §19.1716(g)(3) and §19.2016(h)(3) that the URA must make available all records relating to its operation during any on-site review. Section 19.1714(f)(2) and §19.2014(g)(2) provide that, at a minimum, notice of an unscheduled on-site review of a URA will be in writing and be presented by TDI's designated representative on arrival.

Existing §19.1716(f) and §19.2016(g), relating to lists of URAs, are not included in the adopted rules because TDI now maintains a list of certified URAs on its website that is available to individuals or organizations interested in learning about a URA's certification status. This list is updated in real time. Further, TDI determined that existing §19.1716(g)(4), relating to possible periodic telephone audits of URAs to determine if they are reasonably accessible, is no longer necessary. Insurance Code §4201.601 authorizes TDI to take certain steps if a person or entity conducting utilization review is believed to be in violation of Chapter 4201 or applicable rules. These steps include the authority to compel the production of necessary information if TDI

believes that the URA is in violation of the Insurance Code or rules relating to reasonable accessibility.

Section 19.1715 and §19.2015 address Administrative Violations. Section 19.1715 and §19.2015(a) provide that the commission of fraudulent or deceptive acts in obtaining or using a URA registration is a violation of Insurance Code Chapter 4201. Section 19.1715 and §19.2015(a) contain the same requirements that are in existing §19.1717(f) and §19.2017(e). Insurance Code §4201.601 authorizes TDI to take certain steps if a person or entity conducting utilization review is believed to be in violation of Chapter 4201 or applicable rules.

Section 19.1715 and §19.2015(b) clarify that the commissioner's authority under Subchapters R and U, respectively, is in addition to remedies provided under Insurance Code Chapter 4201, Subchapter M, concerning enforcement.

Section 19.2015(c) clarifies that the provisions in §19.2015 do not limit the joint enforcement actions of TDI and TDI-DWC or delegations of authority to enforce relevant statutes or rules.

These provisions are consistent with Insurance Code Chapter 4201, Subchapter M. Insurance Code §4201.601 permits the commissioner to compel production of information necessary to determine whether a violation has occurred. Additionally, under Insurance Code §4201.603, the commissioner may impose a sanction under Insurance Code Chapter 82, issue a cease and desist order under Insurance Code Chapter 83, or assess an administrative penalty under Insurance Code Chapter 84 if the commissioner determines a person or entity conducting utilization review has violated Insurance Code Chapter 4201.

Section 19.1716 and §19.2016 address Specialty URA requirements. Section 19.1716(a) and §19.2016(a) require a specialty URA to submit to TDI the application, information, and fee required in §19.1704 or §19.2004, respectively, to be certified or registered as a specialty URA. This provision implements Insurance Code §4201.101.

Section 19.1716(b) and §19.2016(b) require a specialty URA to conduct utilization review under the direction of a health care provider who is of the same specialty as the agent and who is licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the U.S. For example, when conducting utilization review of prescription drugs prescribed by a physician with a specialty in neurological surgery, the specialty URA must be a physician with a specialty in neurological surgery. This provision tracks the requirements in Insurance Code §4201.454 and is consistent with Insurance Code §1305.351(d) and Labor Code §408.023(h).

Additionally, under Insurance Code §4201.456, the specialty URA must provide the health care provider who ordered the service a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the agent's determination with a health care provider who is of the same specialty as the specialty URA. A specialty URA must meet the requirements of Insurance Code §4201.002(5), regarding the definition of the term "health care provider," to qualify as a specialty URA.

Section 19.1716(c) and §19.2016(c) provide that a specialty URA is subject to the requirements of Subchapter R or Subchapter U, respectively, except for those rules implementing those statutory requirements from which a specialty URA is exempt. The rules that are not applicable to specialty URAs, as outlined in §19.1716(c)(1) - (4) and §19.2016(c)(1) - (4), are consistent with Insurance Code §4201.452, which provides that a specialty URA is not subject to §§4201.151, 4201.152, 4201.206, 4201.252, or 4201.356.

Section 19.1716(c)(1) and §19.2016(c)(1) provide that specialty URAs are not subject to the requirements of §19.1705(a) and §19.2005(a), respectively, because the requirements regarding review and approval of the utilization review plan are based on Insurance Code §4201.151, from which specialty URAs are exempt. Specialty URAs are required, under §19.1716(d), to use only a health care provider of the appropriate specialty. Under §19.2016(d), specialty URAs are required to use only physicians, doctors, other health care providers, of the appropriate specialty in accord with 28 TAC Chapter 180 (relating to Monitoring and Enforcement). Under Insurance Code §4201.453, a specialty URA must have the utilization review plan reviewed by a health care provider of the appropriate specialty and conducted in accord with standards developed with input from a health care provider of the appropriate specialty.

Section 19.1716(c)(2) and §19.2016(c)(2) provide that specialty URAs are not subject to the requirements of §19.1706(a), (c), and (d) and §19.2006(a) and (c) - (e), respectively, because they implement Insurance Code §4201.252, from which specialty URAs are exempt.

Section 19.1716(c)(3) and §19.2016(c)(3) provide that specialty URAs are not subject to the requirements of §19.1710 and §19.2010, respectively, because those sections implement Insurance Code §4201.206, from which specialty URAs are exempt. Instead, these respective regulatory concerns are specifically addressed for specialty URAs in §19.1716(f) and §19.2016(g) based on the peer-to-peer discussion requirements that specifically apply to specialty URAs under Insurance Code §4201.456.

Section 19.1716(c)(4) and §19.2016(c)(4) provide that specialty URAs are not subject to the requirements of §19.1711(a)(4) - (6) and §19.2011(a)(4) - (5) because those sections implement Insurance Code §4201.206 and §4201.356, from which specialty URAs are exempt.

Section 19.1716(d) and §19.2016(d) require a specialty URA to have the utilization review plan reviewed by a health care provider of the appropriate specialty and conducted in accord with standards developed with input from a health care provider of the appropriate specialty. This provision implements Insurance Code §4201.453.

Section 19.1716(e) and §19.2016(e) address requirements of employed or contracted physicians, doctors, other health care providers, and personnel. Section 19.1716(e) and §19.2016(e) incorporate the requirements of existing §19.1720(f) and §19.2020(f), respectively. Section 19.1716(e)(1) and §19.2016(e)(1) require physicians, doctors, other health care providers, and personnel employed by or contracted with a specialty URA to perform utilization review to be appropriately trained, qualified, and currently licensed. Section 19.2016(e)(1) further requires personnel listed in subsection (e) to be appropriately trained, qualified, and currently licensed in accord with 28 TAC Chapter 180 (relating to Monitoring and Enforcement).

Section 19.1716(e)(2) and §19.2016(e)(2) require personnel conducting specialty utilization review to hold an unrestricted license or an administrative license issued by a state licensing board or the Texas Medical Board, respectively, or to be otherwise authorized to provide health care services in the U.S. or Texas, respectively. This requirement is based on the Utilization Review Advisory Committee recommendation and is

necessary to ensure that all personnel are appropriately trained and qualified to conduct specialty utilization review.

Under §19.2016(f) the utilization review by a specialty URA must be conducted under the direction of a physician, doctor, or other health care provider of the same specialty, and the physician, doctor, or other health care provider must be currently licensed to provide the specialty health care service in Texas. This is consistent with Insurance Code §1305.351 and Labor Code §408.023(h).

Section 19.1716(f) and §19.2016(g) mirror existing §19.1716(h) and §19.2020(h). Section 19.1716(f)(1) and §19.2016(g)(1) provide that when the specialty URA provides the reasonable opportunity required under this subsection, the specialty URA must include its phone number so that the provider of record may contact the specialty URA to discuss the pending adverse determination. This requirement is necessary to give the provider of record the necessary information should the provider of record require further discussion with the specialty URA.

Section 19.1716(f)(2) and §19.2016(g)(2) require the specialty URA to maintain documentation detailing the discussion opportunity provided, including the date and time the specialty URA offered the opportunity to discuss the adverse determination, the time any discussion took place, and the outcome. The specialty URA must submit this documentation to TDI or TDI-DWC, respectively, if requested. These requirements enable TDI to monitor whether reasonable opportunities for discussion are offered and to collect information on peer-to-peer discussion results. This information will assist TDI in ensuring compliance with these requirements and in determining the effectiveness of peer-to-peer discussions.

Section 19.1716(g) and §19.2016(h) clarify that an appeal decision must be made by a physician or other health care provider who has not previously reviewed the case and who is of the same specialty as the specialty URA that made the adverse determination. These provisions are consistent with Insurance Code §4201.457, which governs the appeal decisions for specialty URAs.

Section 19.1717 and §19.2017 address Independent Review of Adverse Determinations. Section 19.1717(a) and §19.2017(a) address notification for life-threatening conditions and track the requirements in existing §19.1721(a). The notification of adverse determination subject to the timeframes discussed in the subparagraphs relate to notices of determination made in prospective and concurrent utilization review. These provisions implement Insurance Code §4201.304.

Section 19.2017(a)(1)(A) and (B) specify the timeframes for notification of an adverse determination based on the status of the coverage. For workers' compensation non-network coverage, the adverse determination notice must be provided within the timeframes specified by 28 TAC §134.600. For workers' compensation network coverage, the adverse determination notice must be provided within the timeframes specified by Insurance Code §1305.353 and 28 TAC §10.102.

Section 19.1717(a)(1) and §19.2017(a)(1)(C) add a requirement that the URA must, at the time of notification of the adverse determination, provide notice of the independent review process. Section 19.1717(a)(1) requires the URA to provide a copy of the request for a review by an IRO form to the enrollee or an individual acting on behalf of the enrollee, and the provider of record, at the time they are notified of the adverse determination. This requirement will inform the enrollee of additional options following an adverse determination and enable the enrollee to quickly and efficiently request independent review. Section 19.2017(a)(1)(C) requires the URA to give notice of the procedure for obtaining a copy of the request for a review by an IRO form. The requirements in §19.1717(a)(1) and §19.2017(a)(1)(C) are necessary to inform the enrollee or injured employee, respectively, of the process for independent review in the event of life-threatening conditions.

Section 19.1717(a)(2) and §19.2017(a)(2) require that the enrollee, or injured employee, respectively, their representative, or their provider of record determine the existence of a life-threatening condition on the basis of the prudent layperson standard. This standard requires that a prudent layperson possessing an average knowledge of medicine and health would believe that the injured employee's disease or condition is life-threatening. This new requirement is necessary to clarify that a health care provider does not have to make the determination that the condition is life-threatening, which provides more flexibility to the enrollee or injured employee as long as the prudent layperson test is met.

Insurance Code §4201.002(7) defines "life-threatening" as a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The statute does not specify who must make the determination that the disease or condition is life-threatening. TDI interprets this provision broadly to allow determination of the existence of a life-threatening condition based on a prudent layperson standard, rather than more narrowly allowing only medical personnel to make the determination. Under this interpretation, an enrollee or injured employee who cannot obtain a medical opinion that his or her condition is life-threatening may still be entitled to a faster notice of adverse determination and immediate access to independent review. This requirement is adopted under TDI's rulemaking authority in Insurance Code §4201.003 to adopt rules to implement Chapter 4201.

Section 19.1717(b) and §19.2017(a)(3) clarify that a party who receives an adverse determination or is denied an appeal involving a life-threatening condition is entitled to review by an IRO. This provision implements Insurance Code §4201.360.

Section 19.1717(c) and §19.2017(b) govern independent review involving life-threatening and non life-threatening conditions. Section 19.1717(c) and §19.2017(b) require the URA, or insurance carrier that made the adverse determination, to notify TDI within one working day from the date the request for an independent review is received. A "working day" is defined by Insurance Code §4201.002(16). The requirement that the URA notify TDI within one working day from the date the request for an independent review is received is necessary because prompt action is needed to initiate the process of independent review to ensure proper and timely medical treatment for enrollees and injured employees. TDI determined that the "working day" requirement will avoid impractical deadlines in situations when the request for independent review is received outside of normal working hours or immediately before the end of a working day.

Section 19.1717(c) and §19.2017(b) also require the URA, or insurance carrier that made the adverse determination, to submit to TDI through TDI's Internet website the request for a review by an IRO form which is submitted to the URA, or insurance carrier that made the adverse determination, by the party requesting independent review. This requirement should result in greater efficiency and in a quicker response time for the injured employee or enrollee who is requesting the independent review.

Under §19.1717(c)(1) and §19.2017(b)(1), TDI, within one working day of receipt of the complete request for independent review, will randomly assign an IRO to conduct the independent review. TDI will notify the URA; payor; IRO; enrollee; or injured employee, respectively; their representative; provider of record; and any other providers listed by the URA as having records relevant to the review of the assignment of the IRO. This prompt assignment is necessary for both life-threatening and non life-threatening conditions because assigning IROs is a primary function of TDI.

The requirements in existing §19.1721(h) are not included in the adopted rules because the requirements are found in Insurance Code §4201.402, and inclusion of the requirements would be repetitive.

Section 19.2017(b)(2) references additional requirements for an independent review of an adverse determination for workers' compensation non-network coverage review under the Texas Workers' Compensation Act and TDI-DWC rules, including but not limited to 28 TAC Chapter 133, Subchapter D. This provision clarifies that these adopted rules do not exempt insurance carriers from TDI-DWC's medical billing rules or otherwise modify their duties under those rules.

Section 19.2017(b)(3) references additional requirements for an independent review of an adverse determination for a workers' compensation network coverage review under Insurance Code Chapter 1305, TDI and TDI-DWC rules, including but not limited to, 28 TAC Chapter 10, Subchapter F, and Chapter 133, Subchapter D. This subsection clarifies that for claims under network coverage these adopted sections are to be applied in tandem with TDI's rules concerning workers' compensation health care networks and with TDI-DWC's rules concerning general medical procedures.

Section 19.1717(c)(2) specifies that the payor, in addition to the URA, must comply with the IRO's determination. This clarification is necessary because sometimes the URA and the payor are different parties. This provision implements Insurance Code §4201.401. Section 19.1717(c)(3) retains the requirements in existing §19.1721(j) and (k) and implements Insurance Code §4201.403.

Section 19.1718 addresses Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans and implements Insurance Code §§843.348, 1301.135, and 4201.304. Insurance Code §1301.0042 provides, in part, that a provision of the Insurance Code or another insurance law of Texas that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan except to the extent that the commissioner determines the provision to be inconsistent with the function and purpose of an exclusive provider plan. Section 19.1718(a) clarifies that the words and terms used in Insurance Code Chapter 1301 and Chapter 843 have the same meaning when used in §19.1718. Section 19.1718(b) retains the requirements in existing §19.1723(a), which track the requirements in Insurance Code §843.348. Section 19.1718(c) and §19.1718(f)(2) do not use the term "business day," as used in existing §19.1723(b) and (f)(2), but instead use the term "working day" for consistency with the other rule provisions that contain the "working day" requirement. The requirements in existing §19.1723(c) are not included in the adopted rules because the requirements are found in Insurance Code §843.348(e), and inclusion of the requirements would be repetitive. Section 19.1718(d) - (i) retains the requirements in existing §19.1723(d) - (i).

Section 19.1718(d)(2) adds a requirement that the initial determination by an HMO or preferred provider benefit plan indicating whether proposed services are preauthorized must be transmitted within 24 hours of receipt of the request and must be followed, within three working days, by a letter notifying the enrollee or the individual acting on behalf of the enrollee and the provider of record of an adverse determination. This requirement is necessary to ensure that prompt written documentation of the adverse determination is provided to the relevant parties.

Section 19.1719 addresses Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans and implements Insurance Code §§843.347, 1301.133, and 4201.304. Insurance Code §1301.0042 provides, in part, that a provision of the Insurance Code or another insurance law of Texas that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan except to the extent that the commissioner determines the provision to be inconsistent with the function and purpose of an exclusive provider plan. TDI clarifies that under Insurance Code §1301.069, in part, verification of medical care or health care services applies to a physician or provider who: (i) is not a preferred provider included in the preferred provider network; and (ii) provides to an insured: (A) care related to an emergency or its attendant episode of care as required by state or federal law; or (B) specialty or other medical care or health care services at the request of the insurer or a preferred provider because the services are not reasonably available from a preferred provider who is included in the preferred delivery network. Section 19.1719(a) clarifies that the words and terms used in Insurance Code Chapter 1301 and Chapter 843 have the same meaning when used in §19.1719. Section 19.1719(a) - (c) retains the requirements in existing §19.1724(a) - (c). The requirements in existing §19.1724(d) are not included in the adopted rules because the requirements are in Insurance Code §843.347(h) and (i), and inclusion of the requirements would be repetitive. Section 19.1719(d) - (i) retain the requirements in existing §19.1724(e) - (k). The requirements in existing §19.1724(l) and (m) are not included in the adopted rules because the requirements are in Insurance Code §1301.133(g) and (h), and inclusion of the requirements would be repetitive.

HOW THE SECTIONS WILL FUNCTION. Section 19.1701 and §19.2001 specify the statutory basis, purpose, and severability of Subchapters R and U, respectively. Section 19.1702 and §19.2002 specify the applicability of Subchapters R and U, respectively. Section 19.1703 and §19.2003 specify the meaning of words and terms when used in subchapters R and U, respectively, unless the context clearly indicates otherwise. Section 19.1704 and §19.2004 specify the applicability of certification or registration requirements, the application and renewal process, procedures for contesting a denial, and the requirement to update information within 90 calendar days after the effective date of the rule.

Section 19.1705 and §19.2005 specify the general standards of utilization review, including the utilization review plan review, special circumstances, screening criteria, referral and determination of adverse determinations, delegation of review, and complaint system. Section 19.1706 and §19.2006 specify the requirements and prohibitions relating to personnel. Section 19.1707 and §19.2007 regulate URA's contact with and receipt of information from health care providers, including reimbursement for providing medical information, a requirement to request all relevant and updated information and medical records to complete the review, sharing information among URA divisions, and the prohibition against requiring observation

of a psychotherapy session or submission of a mental health therapist's process or progress notes.

Section 19.1708 and §19.2008 specify on-site review by a URA. Section 19.1709 and §19.2009 specify notice requirements, elements, and timeframes for determinations made in utilization review. Section 19.1710 and §19.2010 specify requirements prior to issuing an adverse determination. Section 19.1711 and §19.2011 specify written procedures for appeals of adverse determinations. Section 19.1712 and §19.2012 specify the URA's telephone access, and §19.2012 specifies procedures for certain drug requests. Section 19.1713 and §19.2013 specify confidentiality requirements and written procedures on confidentiality. Section 19.1714 and §19.2014 specify regulatory requirements subsequent to certification or registration.

Section 19.1715 and §19.2015 specify administrative violations. Section 19.1716 and §19.2016 specify requirements for specialty URA applications; specialty requirements; exceptions to rule requirements; utilization review plans; employed or contracted physicians, doctors, other health care providers, and personnel; reasonable opportunity for discussion; and appeals. Section 19.1717 and §19.2017 specify independent review of adverse determinations.

Section 19.1718 provides requirements for preauthorization for HMOs and preferred provider benefit plans. Section 19.1719 provides requirements for verification for health maintenance organizations and preferred provider benefit plans.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General.

Comment: Commenters appreciate the work of TDI staff and the Utilization Review Advisory Committee members in proposing these rules, which was a complex task. A commenter appreciates TDI's revisions to the regulations as previously informally proposed. A commenter states that TDI's proposed URA rules are much more streamlined and less complex than the set of utilization review agent rules that were proposed for adoption on June 23, 2011. A commenter generally agrees with the goal of TDI staff to make the utilization review rules for workers' compensation and health consistent whenever possible.

Agency Response: TDI appreciates the supportive comments and acknowledges the hard work of the Utilization Review Advisory Committee.

Comment: Commenters state that the proposal incorrectly attempts to make workers' compensation look more like group health insurance by using group health insurance standards and terms in the workers' compensation system for the review of medical care. The commenters state that this attempt might have adverse effects because workers' compensation is different than health insurance, as is the medical coverage under the two types of insurance. The commenters state that workers' compensation is not a medical program, or a health benefit plan, but a no-fault disability program with a medical component. A commenter clarifies that workers' compensation coverage is limited to disabilities and medical conditions that arise out of a compensable on-the-job injury as set out by legislative enactments. The commenters say that there are very specific standards for entitlement to medical care and legal terms found in the Texas Workers' Compensation Act that are not common to health insurance policies and statutes. The commenters assert that blurring those differences by rule might confuse people and result in more medical disputes.

One commenter states that the Subchapter U proposed rules do not enhance the delivery of appropriate medical care to employees entitled to workers' compensation benefits. The commenter asserts that many of the proposed rules ignore legislative directives to TDI on how the Chapter 4201 statutes are to be applied to workers' compensation. As a result, the commenter asserts that many of these proposed rules are totally inappropriate to workers' compensation and undermine the workers' compensation system.

One commenter states that the changes necessary to align the rules with the Insurance Code, Labor Code, and the rule preamble are significant and need to be made prior to adopting the rules. The commenter requests the proposed rules be withdrawn to allow the rules to be amended in a manner that aligns the rules with Labor Code and TDI-DWC rules to ensure the rules "fit" within the four corners of the law.

One commenter states that the proposed rules for Subchapter U should be withdrawn again and redrafted to properly comply with legislative directives concerning these rules. The commenter asserts that there are so many statutory violations imbedded in these rules that violate both the Insurance Code and Labor Code that this proposed Subchapter U should be withdrawn. The commenter explains that studies of the United States health care system indicate that approximately one-third of the money spent nationally on health care services is for unnecessary and inappropriate health care services. A study conducted by TDI indicates that overutilization of health care services in the Texas workers' compensation system is much higher than the overutilization of services for non-work related injuries and illnesses and produces worse health outcomes and return-to-work outcomes for workers. Despite the fact that overutilization of health care is a national workers' compensation health issue, the proposed rules make utilization review more difficult, more expensive, and discourage health care providers from assisting in utilization review. This has an adverse impact on patients, injured workers, families paying health insurance premiums, employers paying workers' compensation premiums, health benefit plans, and workers' compensation carriers.

This commenter asks (i) why is TDI and not TDI-DWC developing rules regulating persons who perform utilization review of workers' compensation benefits; (ii) why is TDI developing rules regulating persons who do not determine whether or not workers' compensation health care is medically necessary or appropriate; (iii) why do these rules repeatedly resolve conflicts between the Labor Code and Insurance Code Chapter 4201 in favor of Chapter 4201; and (iv) why do these rules make utilization review more difficult and more expensive?

Commenters assert that it is important that the rules do not include non-workers' compensation term definitions and concepts that pose a conflict between the rules and Texas Workers' Compensation Act. The commenters explain that, as proposed, the URA rules include a provision that provides that if there is a conflict between the URA rules and rules adopted by the commissioner of workers' compensation, the rules adopted by the commissioner of workers' compensation prevail. There should be no such provision in the rule. The URA rules should be drafted and adopted in a manner that conforms to the Labor Code, rules adopted by the commissioner of workers' compensation, and recognition of how workers' compensation works in Texas.

Commenters state that there are several inconsistencies between the preamble and rules that need to be addressed prior to the adoption of the rules.

Agency Response: TDI agrees that health insurance and workers' compensation coverage are different products, and issues specifically related to one might not apply to the other. However, one of the purposes of the proposed rules is to implement HB 4290, which includes amendments to Insurance Code Chapter 4201.

TDI disagrees that the proposed rules should be withdrawn for the following reasons. The commissioner of insurance and the commissioner of workers' compensation, in their joint statement to the members of the Utilization Review Advisory Committee dated February 10, 2010, stressed that although Subchapters R and U address a function that is provided in both the health and workers' compensation systems, the rules derive from a common statute, Insurance Code Chapter 4201.

As previously discussed, Insurance Code Chapter 4201, to the extent not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305, applies to workers' compensation utilization review.

Labor Code §402.00111 addresses the relationship between, and respective authority of, the commissioner of insurance and the commissioner of workers' compensation regarding workers' compensation system administration. Section 402.00111(c) provides that the commissioner of insurance develop and implement policies that clearly separate the respective responsibilities of TDI and TDI-DWC. By official order dated October 28, 2005, the commissioner of insurance developed policies that clearly separated the respective responsibilities of TDI and TDI-DWC. The order provided, in part, that the commissioner of insurance and TDI must license and regulate workers' compensation URAs.

Also, Labor Code §402.00111(b) provides, among other things, that the commissioner of workers' compensation may delegate to the commissioner of insurance or to that person's designee any power or duty regarding workers' compensation imposed on the commissioner of insurance or the commissioner of workers' compensation under Labor Code Title 5, including the authority to make final orders or decisions. The delegation must be made in writing.

By official order of the commissioner of workers' compensation dated June 21, 2011, the authority to adopt rules regulating utilization review of a health care service provided to a person eligible for workers' compensation benefits under Labor Code Title 5 was delegated to the commissioner of insurance.

TDI and TDI-DWC have determined that Subchapter R and Subchapter U rules should be consistent whenever possible for the benefit of both regulated entities and consumers.

TDI asserts that although these rules potentially increase the cost of utilization review, medical cost containment, premiums, or administrative costs, they are necessary to implement HB 4290, make other changes necessary for clarity and effective implementation of the Insurance Code Chapter 4201, and improve the regulatory framework for URAs.

Additionally, these rules promote efficient regulation of URAs through the alignment of health and workers' compensation URA certification and registration requirements, utilization review timeframes, and utilization review standards. These rules also align differences in utilization review timeframes and standards within workers' compensation for network and non-network claims.

TDI disagrees that there are any inconsistencies between the proposal preamble and the rules, and the commenter did not provide any examples of inconsistencies.

Comment: A commenter states that inconsistent use of terms, both internally and with reference to corollary but specialized uses in the Labor Code and TDI-DWC rules, in the rule proposal may introduce unintentional confusion leading to dispute. Where definitions of terms in these proposed rules conflict with or confuse existing definitions in the Labor Code and TDI-DWC rules, the rules invite unnecessary inconsistency and should be modified or reconsidered.

A commenter notes that the use of group health terminology within the Subchapter U rules pertaining to workers' compensation, including "payor" and "provider" of record, may lead to unnecessary confusion and disputes. Under the rules of statutory construction embodied in Government Code Chapter 311 and relevant cases and rules, the use of differing terms are assigned deferent meanings to give meaning to the entire statute (or rule) and each word used.

Agency Response: TDI considered Labor Code provisions when developing both terminology and timeframes. However, as previously discussed, Insurance Code Chapter 4201, to the extent not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305, applies to workers' compensation utilization review.

Comment: A commenter notes that TDI references the report of the Utilization Review Advisory Committee in support of some of the proposals but has not included references when the committee opposed the requirements now included in these proposals. The commenter suggests that such references be included in the adoption order for complete background information.

Agency Response: TDI declines to make the suggested change. TDI acknowledges that there are many stakeholders affected by the rule in addition to the Utilization Review Advisory Committee members. TDI also recognizes that the Utilization Review Advisory Committee's role was to advise the commissioner on development of rules regarding the administration of Insurance Code Chapter 4201, as provided in Insurance Code §4201.003. TDI recognizes that the Utilization Review Advisory Committee has since been abolished by HB 1951, 82nd Legislature, Regular Session, effective September 1, 2011. However, in recognition of the Utilization Review Advisory Committee's statutory charge prior to its abolishment, TDI has considered all of the Utilization Review Advisory Committee recommendations, and this adoption order identifies the reasoned justification for the adoption of each of these rules.

Comment: A commenter states that prior informal drafts of these rules took into account the possibility that a URA would use performance tracking data. The law and rule neither require nor prohibit the use of performance tracking data. However, if performance tracking data is used, the utilization review plan must provide prior written notice to a physician, doctor, or other health care provider and an opportunity to correct reports prior to publishing data that identifies the particular physician, doctor, or other health care provider, including quality review studies or performance tracking data. This section should be amended to add a new subsection (g) that would include such requirements if performance tracking data were used.

Agency Response: TDI declines to make the suggested change. The suggested provisions reflect the statutory requirements of Insurance Code §4201.556, which states, "A utilization review agent may not publish data that identifies a particular physician

or other health care provider, including data in a quality review study or performance tracking data, without providing prior written notice to the physician or other provider." The suggested change would not require anything additional to the statutory requirements under Insurance Code §4201.556(a), and would be redundant.

Comment: A commenter states that prior informal drafts of these rules included the issue of a prescription drug being the subject of an adverse determination. The commenter asserts that the provision should be included so that the rules can address the specific denial of a particular drug, especially in the case where the patient's physician has determined that the drug is medically necessary. As an adverse determination, the patient can take a drug denial through the established process. The commenter states that the language should be retained and added as a new subsection (h) which would read as follows: (h) Pursuant to the Insurance Code §1369.056, the refusal of a group health benefit plan issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for purposes of this subchapter if: (1) the drug is not included in a drug formulary used by the group health benefit plan; and (2) the enrollee's physician has determined that the drug is medically necessary.

Agency Response: TDI declines to make the suggested change. The requirement is already contained in Insurance Code §1369.056, and adopted §19.1702(b) explains that provisions of Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services, apply to Subchapter R. The suggested change would not require anything additional to the statutory requirements under Insurance Code §1369.056, and would be redundant.

Comment: A commenter suggests that all references to providing notice to or permitting action by injured employees, their representatives, and health care providers also include ombudsmen as persons acting on behalf of injured employees. The commenter points out that many injured employees proceed through the medical dispute resolution process with the assistance of the OIEC ombudsmen because of the unavailability of attorneys' fees. Because the medical dispute resolution process has many tight deadlines, the commenter reasons that it is critical that the Ombudsmen receive notice and be permitted to act on behalf of the injured employee to satisfy the mandate of Labor Code §404.151(b)(5) to "assist unrepresented claimants to enable those persons to protect their right in the workers' compensation system."

The commenter believes that the ombudsmen are representatives under 28 TAC §150.3(a)(3) and Labor Code §401.011(37). The commenter states that OIEC is required under the Memorandum of Understanding Concerning Confidential Information with TDI-DWC to file written authorization from the claimant allowing the Ombudsmen access to confidential records. OIEC ombudsmen do not receive a fee or remuneration directly or indirectly from claimants. Although OIEC ombudsmen maintain an adjuster's license, they do not function as an adjuster when they assist injured employees in the dispute resolution process. In fact, they are only required to have an adjuster's license because the agency adopted that requirement as part of the training and continuing education standards for Ombudsmen. See 28 TAC §276.10. OIEC ombudsmen serving as lay representatives, even though they have an adjuster's license, is comparable to TDI-DWC's long-standing policy of permitting licensed attorneys, who also maintain an adjuster's license, to appear as adjusters in the dispute resolution process.

Agency Response: TDI disagrees with the suggested change. The proposed rules do not prohibit the OIEC Ombudsman from assisting the injured employee. However, expanding the role of the OIEC to act on behalf of the injured employee is beyond TDI's authority. Labor Code Chapter 404 does not authorize an OIEC Ombudsman to act as a representative for the injured employee. The adopted language mirrors language in Insurance Code §1305.355(a), which relates to the independent review of adverse determinations in certified network cases.

Comment: A commenter requests that TDI review §§19.2005, 19.2006, and 19.2009 - 19.2011 to assure consistency of terminology among the sections. Sometimes the term "physician, doctor, or health care provider" is used and sometimes only the term "physician" is used.

Agency Response: TDI clarifies that under §19.2005(e), a physician, doctor, or health care provider may issue an adverse determination under certain circumstances. This provision is consistent with Insurance Code §4201.153, that provides appropriate non-physician and non-doctor health care providers may issue an adverse determination on a health care service in certain circumstances. However, under §19.2005(a), the utilization review plan must be reviewed and approved by a physician. This provision is consistent with Insurance Code §4201.152, that requires utilization review be performed under the supervision of a physician.

Section 19.2006(b) includes the terms "physician, doctor, or health care provider" to reflect the fact that a health care provider can render an adverse determination. Section 19.2009(b) requires the written notification of an adverse determination to include the professional specialty and Texas license number of the physician, doctor, or other health care provider that made the adverse determination. This provision is also consistent with the fact that a health care provider can render an adverse determination under Insurance Code §4201.153.

Comment: A commenter requests that §19.2001(c)(1) be amended to align it closely with one of the core goals of §408.021 of the Texas Workers' Compensation Act, which is to promote the cost effective delivery of quality health care that cures or relieves the effects naturally resulting from a compensable injury, including reasonable expenses incurred by the employee for necessary treatment to cure and relieve the employee from the effects of an occupational disease before and after the employee knew or should have known the nature of the disability and its relationship to the employment; promotes recovery; or enhances the ability of the employee to return to or retain employment. The commenter states that, as currently proposed, the rule provides that the focus of utilization review should be on promoting the delivery of quality health care in a cost-effective manner and providing for the injured employees' safety. The stated purpose of the rules ignores the intent of the Legislature, which is clearly stated in Labor Code §402.021 and §408.021. The commenter suggests the words "cost effective" be added in §19.2001(c)(1) after the words "promote the." The commenter further suggests that the words "in a cost-effective manner, including protection of injured employee safety" be deleted and replaced with "reasonably required to treat the injured employee's compensable injury and that cures or relieves the effects naturally resulting from the compensable injury, including reasonable expenses incurred by the employee for necessary treatment to cure and relieve the employee from the effects of an occupational disease before and after the employee knew or should have known the nature

of the disability and its relationship to the employment; promotes recovery; or enhances the ability of the employee to return to or retain employment."

A commenter requests that the term "health" be replaced with the term "medical" in §19.2001(c)(1) to bring 28 TAC §19.2001(c)(1) more in line with 28 TAC §180.19(a)(5), which provides that one of the key regulatory goals for workers' compensation is to "ensure each injured employee shall have access to prompt, high quality, cost-effective medical care."

A commenter asserts that the proposed rule fails to specify that workers' compensation utilization review must include the concept that the planned medical care is both reasonable and appropriate to treat the workplace injury and in accord with evidence-based medicine. The commenter asserts that §19.2001(c)(1) of the proposed rule should be modified to include the concept that the purpose of utilization review is to determine if the service or proposed service is actually reasonably required by the nature of the compensable injury and whether the service or proposed service is clinically appropriate and effective for the injury and provided in accord with best practices consistent with evidence-based medicine or, if evidence-based medicine is not available, generally accepted standards of medical practice recognized in the medical community.

Agency Response: TDI disagrees with the suggested changes. Adopted §19.1701(c) and §19.2001(c) track Insurance Code §4201.001, regarding the purpose of Insurance Code Chapter 4201, with the addition of the word "medical" as a clarifying change in §19.1701(c)(4) and §19.2001(c)(4) because "medical records" is a defined term. TDI asserts that the use of the term "medical care" instead of the term "health care" in §19.2001(c)(1) would not add clarity because the term "health care" is used throughout Subchapter U. The concepts of cost-effectiveness, reasonableness, and appropriateness are adequately contained in the applicable statutes and adopted rule.

Comment: A commenter requests that the proposal preamble language for §19.2002(a)(2) be set forth directly in the applicability section to specifically clarify that persons performing administrative tasks are not subject to the proposed rules.

A commenter asserts that the agency generated amendment to Insurance Code §4201.051 changes the meaning of the statute. The commenter asserts that the apparent purpose of this change is to limit the applicability of Insurance Code §4201.051 and to expand the authority of TDI to regulate a wide variety of persons who do not determine medical necessity or appropriateness. This commenter further notes that Texas appellate courts have told TDI that it can only exercise such authority as is conferred upon it in "clear and unmistakable terms by the legislature" and "its authority will not be extended by inference but must be strictly construed." *Hamaker v. American States Ins. Co. of Texas* 493 S.W.2d 893 (Tex. Civ. App. Austin 1973, ref. n.r.e.); *Key Western Life Insurance Co. v. State Bd. of Ins.* 350 S.W.2d 839 (Tex. Sup. 1961); *Lawyers Title Ins. Corp. v. Board of Insurance Commissioners* 207 S.W.2d 972 (Tex. Civ. App.-Austin 1948). The commenter asserts that TDI's interpretation of this statute is based on a legally impermissible inference and is inappropriate.

A commenter requests that TDI amend the rule to replace the word "person" with "administrative staff" and to replace the phrase "provided for under workers' compensation insurance coverage, but that does not determine medically necessary or appropriate or necessity or appropriateness or the experimental or investigational nature of health care services" with "benefits whether a particular health care service provided or to be provided to an injured employee is medically necessary or appropriate or experimental or investigational." The commenter asserts the recommended language tracks more closely the actual language of Insurance Code §4201.051 and more clearly clarifies that the rules do not apply to persons who handle administrative processes within the utilization review process and do not determine the medical necessity or appropriateness or the experimental or investigational nature of the health care service.

Agency Response: TDI agrees in part and disagrees in part. TDI agrees that the clarification should be made to §19.2002(a)(2) to more closely track Insurance Code §4201.051; however, TDI disagrees with the commenter's suggested language. TDI made changes to §19.2002(a)(2), and conforming changes to §19.1702(a)(2), to more closely track Insurance Code §4201.051 by replacing the word "that" with "who" and replacing the words "but that" with "and." The preamble states that the proposed rules "clarify that a person performing administrative tasks for a URA, that does not determine medical necessity or appropriateness, or the experimental or investigational nature, of the health care services, is not subject to the proposed regulations." TDI declines to replace the word "person" with "administrative staff" because the language in adopted §19.2002(a)(2) and §19.1702(a)(2) tracks the language in Insurance Code §4201.051 and the suggested change would not add any clarity. TDI asserts that the purpose of §19.2002(a)(2) is to track Insurance Code §4201.051 and not to expand the authority of TDI to regulate a wide variety of persons, who do not determine medical necessity or appropriateness.

Comment: Commenters raise concerns regarding the proposed rules' requirements that physicians performing required medical examinations be subject to the proposed utilization review rules in §19.2002(b)(1). Commenters assert that proposed §19.2002(b)(1) is being read by the insurance and utilization review industries as requiring peer review and requiring medical examination doctors to comply with all provisions of the proposed URA rules. The commenters explain that peer review doctors, who conduct an administrative review of medical records, and required medical examination doctors, who conduct a hands-on examination of an injured employee and review their medical records, render an opinion of the medical necessity and appropriateness of healthcare treatment. The commenters state that peer review doctors and required medical examination doctors are not subject to Chapter 4201 of the Insurance Code and TDI's URA rules.

Commenters explain that the Legislature has defined the role of required medical examinations in the Texas Workers' Compensation Act. Commenters further state that Labor Code §408.004 provides that the commissioner of workers' compensation may require an employee to submit to required medical examinations to resolve any question about the appropriateness of the health care received by the employee. Labor Code §408.004 also provides that the commissioner may require an employee to submit to a medical examination at the request of the insurance carrier, but only after the insurance carrier has attempted and failed to receive the permission and concurrence of the employee. The Labor Code also provides that required medical examinations can be requested and performed to determine whether there has been a change in the employee's condition and whether it is necessary to change the employee's diagnosis.

Commenters assert that the Labor Code does not define required medical examinations as utilization review, and the Insurance Code does not define required medical examinations as utilization review. The commenters note that a required medical examination is not a utilization review process, as no specific claim action is taken as the result of the hands-on examination and review of medical records of an injured employee. The required medical examination doctor provides an opinion as to whether the treatment is appropriate, but the ultimate decision whether to adopt that position is made by the carrier's medical advisor or utilization review agent. Required medical examinations are no more utilization review than is an independent review of health care by an independent review organization or a health care quality review conducted by TDI-DWC's Medical Quality Review Program. All of these processes have a specific purpose defined in the Labor Code. The commenters request that TDI delete all requirements that a required medical examination physician be subject to the proposed utilization review rules because there is no statutory authority to require medical examination physicians to be subject to the utilization review rules, and such requirements jeopardize the independence of required medical examination physicians. The commenters further state that, if required medical examinations and peer reviews are deemed to be utilization review, then this provision of the rule would also have to apply to employee requested post designated doctor required medical examinations, designated doctors, and all referral and consulting doctors selected by the treating doctor. The commenters further explain that the utilization review statute was never intended to regulate examining doctors, but rather was only intended to regulate utilization review agents that address medical necessity issues.

A commenter states that, at the request of an insurance industry work group that reviewed the proposed URA rules, the commenter contacted TDI-DWC and discussed this rule provision with a senior member of TDI-DWC's staff who has been involved in drafting the URA rules. The commenter asserts that they were informed that the intent of this subsection of §19.2002 is to clarify that the peer review doctor and required medical examination doctor must be an employee of or contracted with the URA doctor rendering the adverse determination if relying on the peer review or required medical examination report when making the retrospective utilization review adverse determination. The commenter respectfully points out that neither the Insurance Code nor the Labor Code requires peer review and required medical examination doctors to either be an employee of or contracted with a URA under any circumstances. As such, there is no statutory provision that allows or directs TDI to include the requirement set forth in this subsection in the URA rules. The commenter requests that TDI delete §19.2002(b)(1).

Alternatively, this commenter requests that §19.2002(b)(1) be amended to include an alternative that the paragraph track the language of the Chapter 180 rule addressing the duties and responsibilities of a peer review doctor and eliminate all reference to required medical examination doctors.

A commenter opines that the apparent purpose behind §19.2002(a)(2) of the rules is to allow TDI to regulate peer reviewers and required medical examination doctors under §19.2002(b)(1). The commenter states that there is no statutory language in Chapter 4201 that justifies the expansion of the applicability of that chapter and these rules to a person who "does not determine whether a particular health care service provided or to be provided is medically necessary or appropriate . . ." and the statutes prohibit applicability in this regard. The commenter asserts that peer reviewers and required medical examination doctors do not determine medical necessity.

Additionally, the commenter asserts that TDI-DWC, and not TDI, has limited authority to regulate peer reviewers and required medical examination doctors under Labor Code §408.004 and §408.0231 and not the Insurance Code. The commenter asserts that for TDI to usurp and exceed this authority granted to TDI-DWC is inappropriate. The commenter further notes that TDI-DWC has already exercised this authority as found in 28 TAC §§126.6, 180.22, and 180.28. The commenter further asserts that TDI regulations directly conflict with existing TDI-DWC regulations. The commenter explains that the conflict can be avoided by deleting these illegal and unnecessary rule provisions.

The commenter asks whether all health care providers who express opinions on the necessity and appropriateness of medical care should be regulated under the URA rules. The commenter also asks whether TDI is attempting to ensure that all medical opinions utilized by the URA to make a utilization review determination are rendered by a health care provider that is employed by or under contract with the URA, and states that, if so, this would be sheer foolishness. The commenter notes that there is no statutory authority in the Insurance Code or the Labor Code to allow TDI to mandate such an employment or contractual relationship.

A commenter asks whether §19.2002(b)(1), that the commenter opines is a TDI generated statutory rewrite and expansion of authority, is aimed at correcting a problem with the utilization of medical care in the workers' compensation system. The commenter explains that TDI studied the utilization of health care in the workers' compensation system in 2001 and found that injured workers in Texas receive six times as much treatment as persons with the same injury who were not injured on the job. This overutilization of medical care produced worse return to work and health outcomes for workers' compensation claimants than for persons treated outside of the workers' compensation system. The commenter further states that peer reviewers and required medical examination doctors did not create this problem. There is some evidence that the overutilization of medical care in the workers' compensation system has moderated since the enactment of workers' compensation reforms in 2001 and 2005. However, there is no evidence that overutilization of health care in the workers' compensation system has abated to the point that treatment in the workers' compensation system mirrors treatment outside of the system. The commenter requests that TDI repeat the 2001 study and publish the results.

Finally, the commenter states that §19.2002(b)(1), together with proposed §19.2004(a), requires all peer reviewers and required medical examination doctors to become registered utilization review agents and is inappropriate. The commenter recommends §19.2002(b)(1) be deleted in its entirety.

A commenter states that the issue is not whether peer reviews and required medical examination doctors should be regulated; they should be regulated and already are regulated by statute and rule. However, they are not performing utilization review, are not determining whether health care services should be paid or denied reimbursement, and should not be regulated as utilization review agents. The commenter asserts that proposed §19.2002(b)(1) should be stricken as inconsistent with the workers' compensation law and the Insurance Code and as outside the authority of TDI.

A commenter asserts that 28 TAC §180(g) recognizes that peer reviewers are URAs in some cases, but does not provide the same for required medical examinations.

A commenter requested clarification of §19.2002(b)(1), because the rule appears to require all peer reviews to comply with all utilization review requirements of the entirety of Subchapter U, which may be overly broad and unnecessarily burdensome. The commenter explains that peer reviews may be used for a multitude of purposes from internal information and decision making unrelated to health care provider utilization requests, as tools to decide if utilization review is needed, or to opine on extent of injury issues. The commenter offers that it may be more appropriate to require peer review compliance with Subchapter U in cases where the health care provider is seeking authorization that is either wholly or partly denied based in part on a peer review report. The commenter states that the provisions of 28 TAC §180.22(g), making Insurance Code Chapter 4201 applicable to peer reviewers who perform utilization review, should not be expanded beyond this applicable rule.

Agency Response: TDI agrees to clarify §19.2002(b)(1) to avoid confusion among system participants as to the applicability of the URA rules to all required medical examinations; however, TDI notes that a required medical examination may qualify as utilization review under certain limited circumstances. Specifically, a required medical examination that is performed pursuant to Labor Code §408.004 may qualify as utilization review under the current definition of utilization review if the examination is intended to review the medical necessity or appropriateness of an injured employee's health care services. TDI further clarifies that designated doctor examinations and required medical examinations under Labor Code §408.0041 never qualify as utilization review, because these examinations do not review the medical necessity or appropriateness of an injured employee's health care services and only address issues such as the ability of an injured employee to return to work, the injured employee's maximum medical improvement date or impairment rating, the extent of the injured employee's compensable injury, and other related issues.

In terms of the applicability of utilization review requirements to peer review functions in the Texas workers' compensation system, TDI reminds stakeholders that §180.22(g), which was first adopted in 2006 and later updated in 2011, states, in part, that "a peer reviewer who performs prospective, concurrent, or retrospective review of the medical necessity or reasonableness of health care services (utilization review) is subject to the applicable provisions of the Labor Code; Insurance Code, Chapters 1305 and 4201; and TDI and TDI-DWC rules." This rule further states that a peer reviewer who performs utilization review must be certified or registered as a URA by TDI or be employed by or under contract with a certified or registered URA. The language in §19.2002(b)(1) reminds stakeholders of the requirements that already apply to peer reviewers under the 28 TAC Chapter 180 rules.

TDI clarified §19.2002(b)(1) by deleting "or required medical examinations under Labor Code §408.004," and by making the section into one sentence to clarify the applicability to peer reviewers, by moving "and" to the end of the phrase "must generate a written report," and deleting both the period at the end of the sentence, and "Peer reviewers" at the beginning of the following sentence. TDI deleted the sentence, "Required medical examination doctors must comply with this subchapter, Labor Code Title 5, and rules adopted under the Texas Workers' Compensation Act including, but not limited to, Chapter 126 of this title (relating to General Provisions Applicable to All Benefits); Chapter 134, Subchapter B, of this title (relating to Miscellaneous Reimbursement); and Chapter 180 of this title."

Comment: A commenter strongly supports §19.2002(b)(1) which clarifies that required medical examination doctors must comply with regulations under Subchapter U, Labor Code Title 5, and rules adopted under the Texas Workers' Compensation Act. Such regulation protects the injured worker by assuring that all physicians who perform peer reviews meet and comply with appropriate standard of care and regulatory requirements.

Agency Response: TDI appreciates the supportive comment. However, as previously discussed, TDI deleted the required medical examination language from adopted §19.2002(b)(1).

Comment: A commenter appreciates that clarification in §19.2002(b)(3). Another commenter supports the adoption of §19.2002(b)(3) and §19.2002(b)(4).

Agency Response: TDI appreciates the supportive comments. §19.1703 and §19.2003. Definitions.

Comment: A commenter requested TDI add language to the definition of "adverse determination" in §19.2003(b)(1) to explain, "this term does not include a peer review by a URA that is not used as a basis to deny authorization or reimbursement for health care."

Agency Response: TDI declines to make the suggested change. Peer review is defined in adopted §19.2003(b)(24), and TDI clarifies that the requirements contained in adopted Subchapter U do not apply to peer reviews performed for issues other than the review of medical necessity or appropriateness of health care, such as compensability or an injured employee's ability to return to work.

Comment: A commenter asserts that TDI introduces terms into Subchapter U that conflict with existing terms and definitions found in the Labor Code. Insurance Code §4201.054(c) expressly mandates that Labor Code Title 5 prevails over Insurance Code Chapter 4201 when there is a conflict. The commenter notes that TDI has corrected some of the conflicts but has maintained other conflicts. The commenter expresses concern that introducing new and conflicting concepts into this subchapter creates confusion for stakeholders and can lead to the misapplication of the rules. The commenter asserts that terms that should be deleted and not used in the rules include the following: "insurer," "mental health therapist," "payor," "person," and "provider of record." In addition, TDI introduces other terms not found in the definitions section that should be deleted, including "physician" and "life-threatening condition" which are inappropriate for the workers' compensation subchapter.

Agency Response: TDI declines to delete "payor," "mental health therapist," "person," and "provider of record" from the terms defined in §19.2003(b) because it would result in inconsistent definitions between these adopted rules and Insurance Code Chapter 4201 as well as result in inconsistent definitions under Subchapters R and U. TDI clarifies that the terms "physician" and "life-threatening condition" are defined in Insurance Code §4201.002.

For purposes of clarification, the term "payor" includes an insurance carrier or insurer. The statutory definition of "payor" in Insurance Code §4201.002(10) does not conflict with Insurance Code Chapter 1305 or Labor Code Title 5. TDI has tailored the definition of "payor" to include a person or entity that provides,

offers to provide, or administers workers' compensation benefits, in recognition that the definition of "payor" under Subchapters R and U should not be identical.

Retaining the reference to "payor" in Subchapter U also is necessary because sections specifically distinguish between situations where the insurance carrier is, or is not, the payor. Under §19.2017(b)(1), the term "payor" is also necessary for consistency with the IRO rules under 28 TAC §12.1, which contemplate an IRO's interaction with URAs and payors.

The term "mental health therapist" is used in §19.2007(d), which implements Insurance Code §4201.303. Under Insurance Code §4201.303, a URA is prohibited from requiring, as a condition of treatment approval or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes.

TDI clarifies that the "provider of record" is the individual requesting treatment on behalf of the injured employee and is the point of contact for the URA to discuss a pending adverse determination, request records, and provide notice of favorable or adverse determinations. This definition of "provider of record" mirrors the definition in proposed §19.1703 and is necessary to track Insurance Code §4201.002(12). Insurance Code §4201.002(12) defines "provider of record" as the physician or other health care provider with primary responsibility for the care, treatment, and services provided to an enrollee. The term includes a health care facility if treatment is provided on an inpatient or outpatient basis. Insurance Code Chapter 4201, to the extent not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305, applies to workers' compensation utilization review. Insurance Code §4201.003(a) grants the commissioner general rulemaking authority to implement Insurance Code Chapter 4201. TDI asserts that there is no direct conflict with the use of "provider of record" and Labor Code Title 5. Thus, TDI has rulemaking authority to define and utilize the term "provider of record" throughout the Subchapter U rules.

The term "life-threatening" is defined in Insurance Code §4201.002(7), and proposed §19.2003(a) provides that the words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in this subchapter, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise. TDI clarifies that the concept of "life-threatening" conditions is already introduced into the workers' compensation system. For example, the IRO regulations under 28 TAC §12.5 define "life-threatening condition," and §12.205 and §12.206 contain requirements specific to instances of life-threatening conditions. Title 28 TAC §133.305 also defines "life-threatening," and 28 TAC §133.308(h) provides that in a preauthorization or concurrent review dispute request, an injured employee with a life-threatening condition is entitled to an immediate review by an IRO and is not required to comply with procedures for a reconsideration. TDI is not introducing a new concept into the workers' compensation system by adopting these regulations.

The term "physician" is defined in Insurance Code §4201.002(11), and proposed §19.2003(a) provides that the words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in this subchapter, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise. TDI clarifies that under §19.2005(d), a physician, doctor, or health care provider may issue an adverse determination under certain circumstances. This provision is consistent with Insurance Code §4201.153, that provides appropriate non-physician and non-doctor health care providers may issue an adverse determination on a health care service in certain circumstances. However, under §19.2005(a), the utilization review plan must be reviewed and approved by a physician. This provision is consistent with Insurance Code §4201.152, that requires utilization review be performed under the supervision of a physician.

Comment: A commenter asserts the provision in §19.1703(b)(1) and §19.2003(b)(1) that "adverse determination" does not include a denial of health care services due to the lack of prospective or concurrent utilization review will close any loophole that would allow a provider to request a retrospective review after their medical bill has been denied for lack of prior authorization.

A commenter supports the definition of "adverse determination," specifically the second sentence of the definition

Agency Response: TDI appreciates the supportive comments.

Comment: A commenter requests clarification as to whether §19.2003(b)(1) means that determinations that services or devices are experimental or investigational is not grounds for an automatic denial based solely on the finding that the service or device is experimental or investigational. The commenter asserts that such experimental or investigational services or devices may independently be denied under an adverse determination based on other proper reasons for a denial, for example, the service or device is otherwise medically inappropriate or unnecessary on stated grounds in the same way a proposed spinal surgery must pass through preauthorization or concurrent review based on its medical merits. The commenter explains that 28 TAC §134.600(p)(6) and (q)(4) effective July 1, 2012, mandates preauthorization and concurrent review for experimental or investigational services or devices. The commenter notes that proposed rule language is readily misconstrued to mean that no adverse determination may be made when proposed services or devices are experimental or investigational. The commenter recommends that this definition be changed to conform with the workers' compensation standard for entitlement to medical care found in Labor Code §401.011(22-a) and §408.021.

Commenters explain that the language in the proposed rule suggests that the standard for entitlement to workers' compensation medical treatment is "medically necessary or appropriate." Labor Code §408.021 expressly states that the injured worker is entitled to "... all health care reasonably required by the nature of the injury as and when needed." The term "health care reasonably required" is specifically defined in the Texas Workers' Compensation Act at Labor Code §401.011(22-a). This term is not defined in the Texas Workers' Compensation Act and is subject to an interpretation that could differ from the statutory standard of "health care reasonably required."

A commenter asserts that this definition conflicts with the statutory definition found in Insurance Code §4201.002(1) and the standards for health care coverage found in the Texas Workers' Compensation Act. Insurance Code §4201.054(c) expressly mandates that Labor Code Title 5 prevails over Insurance Code Chapter 4201 when there is a conflict. The commenter asserts that this is another incident in which TDI wrongly decided that Insurance Code Chapter 4201 prevails over the Labor Code.

A commenter recommends alternative language to replace "medically necessary or appropriate" with "reasonably required."

A commenter recommends §19.2003(b)(1) be modified to state that an adverse determination is a determination that the health

care services provided or to be provided are not "reasonably required by the nature of the injury and is not clinically appropriate and considered effective for the injured employee's injury and provided in accord with best practices consistent with evidence based medicine or if that evidence is not available, generally accepted standards of medical practice recognized in the medical community."

A commenter suggests that §19.2003(b)(1) be clarified to state that the term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review in accord with the requirements specified by the URA or payor.

A commenter recommends that §19.1703(b)(1) be clarified to state that the term does not include a peer review by a URA that is not used as a basis to deny authorization or reimbursement for health care.

A commenter asserts that the sentence, "the term does not include a denial of health care services due to the failure to request prospective or concurrent review," in §19.1703(b)(1) is inappropriate and should be struck. The commenter explains that the sentence is contrary to what the definition of "utilization review" allows in Insurance Code §4201.002.

Commenters express a variety of concerns over the definition of adverse determination in §19.1703(b)(1). The commenters note that the definition classifies an insurer and workers' compensation carrier retrospective denial for medical necessity as an adverse determination and provides access to an IRO if requested. Most requests for retrospective review will be because a prospective or concurrent review for medically necessity was neither requested by the provider nor performed by the carrier. Denials for failure to request a prospective or concurrent review for medical necessity are included under the definition of retrospective review when one reads the statutory definition of "adverse determination" together with the statutory definition of "utilization review." The result is that retrospective review requests for denials for medical necessity should be considered adverse determinations. The commenter asserts that the proposed definition conflicts with current statutory language as it would negate the ability to request and obtain an actual review of medical necessity after a service or procedure is rendered. The commenter asserts that TDI is revoking the statutory inclusion of retrospective review as part of the definition of utilization review. The service or procedure is no less entitled to review for medical necessity because such review is retrospective.

A commenter asks TDI to consider instances where a physician wants to use an experimental or investigational treatment when other established treatments with the same outcomes are available.

Agency Response: TDI declines to make the suggested deletion. The phrase "medically necessary or appropriate" is consistent with the definition of "adverse determination" under the Insurance Code §4201.002, which defines "adverse determination" as a determination by a URA that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational. Also, the phrase "medically necessary or appropriate" is used in 28 TAC §12.5(1), which defines "adverse determination" for purposes of independent review. Introducing the phrase "health care reasonably required" would result in inconsistent definitions of "adverse determination" in the context of utilization review and independent review.

Nothing may be construed to limit healthcare reasonably required under Labor Code §408.021. TDI's position is that, based on Labor Code §408.021, an injured employee under both network and non-network coverage is entitled to health care reasonably required by the nature of the injury as and when needed, including experimental and investigational health care services. For this reason, TDI further clarifies in §19.2003(b)(1) that for purposes of Subchapter U, the term "adverse determination" does not include a determination that health care services are experimental or investigational.

Comment: A commenter raises concerns with the term "appeal" in §19.2003(b)(2), which also applies to reconsideration processes prescribed by Labor Code Title 5. The commenter notes that one concern is that medical bill review might be treated as a utilization review because it is a retrospective review. The commenter requests clarification in the proposed rule between the terms "utilization review" and "retrospective review."

Agency Response: TDI clarifies that the term "utilization review" is defined in Insurance Code §4201.002. Section 19.2003(a) states that the words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in this subchapter, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise.

Comment: Commenters do not support including the phrase "that may reasonably be perceived as having potential to" in the definition of "disqualifying association" in §19.2003(b)(8) because it is too subjective and should be deleted. Commenters assert that the phrase "may reasonably be perceived as having potential to" in §19.2003(b)(8) is too broad, ambiguous, extremely subjective, and confusing. Commenters recommend the definition be modified by deleting the phrase "that may reasonably be perceived as having potential to."

A commenter states that the standard for determining a "disqualifying association" should be an association that actually influences the conduct or decision of a reviewing physician, doctor, or health care provider.

A commenter notes that certain subjective bases contained in the rule (for example, respecting disqualifying associations) do not provide adequate guidance to participants in determining appropriate conduct.

A commenter states that the proposed definition for disqualifying association based on personal or family relationships is vague in that it fails to specify the degree of consanguinity that would create a relationship that is a disqualifying association. For consistency, Government Code Chapter 573 may aid in clarification.

A commenter requests that TDI amend the definition of "disqualifying association" to prevent the requesting provider of exercising bias and prejudice based solely on the fact that they received an adverse determination by a reviewer.

Agency Response: TDI disagrees with the suggested changes. The definition of "disqualifying association" includes "any association that may reasonably be perceived as having potential to influence the conduct or decision of a reviewing physician or doctor." This reasonableness standard can be used to evaluate whether a personal or family relationship may be considered a disqualifying association.

TDI declines to further clarify the definition of "disqualifying association." The reasonableness standard is more flexible than a detailed list of specific family relationships that are always considered to be disqualifying associations.

Comment: A commenter raises concerns of the term "doctor" in §19.2003(b)(9). The commenter notes that the definition of the term "doctor" under proposed §19.2003(b)(9) mirrors the definition in Labor Code §401.011. However, this definition specifically excludes psychologists, doctorate in pharmacology and doctorate in physical therapy and other licensed health professionals - all of whom are "health care practitioners" as defined by Labor Code §401.011(21) and as such might need to be used in the utilization review process for the reconsideration process. The commenter suggests the addition of the definition for health care provider in the Insurance Code §4201.002. The commenter recommends the Insurance Code reference (in contrast to the Labor Code definition) due to the limited scope of the definition of "health care provider" in the Labor Code. Additionally, the commenter notes that the definition of this term is in the existing utilization rules that are proposed to be repealed, but it was not included in these new proposed rules.

A commenter notes that the proposed rules do not use the term "health care practitioner" throughout the rules as one of the persons that may conduct utilization review. The commenter believes that TDI should define the term "health care practitioner" as it is defined in Labor Code §401.11{sic}. The term should be used in the manner set out in several of the commenter's written comments so as to clarify that psychiatrists, psychologists, and other health care provider specialties, e.g. physical therapists, may conduct utilization review when appropriate. The commenter requests that TDI add a definition for the term "health care provider" to §19.2003 as "an individual who is licensed to provide or render and provides or renders health care or a nonlicensed individual who provides or renders health care under the direction or supervision of a doctor."

A commenter notes that the proposed rules use the term "health care provider" throughout the rules as one of the persons that may conduct utilization review. The term "health care provider" is not defined. The commenter believes that TDI should replace the term "health care provider" with the term "health care practitioner" and adopt the definition of the term "health care practitioner" that is set out in Labor Code §401.11{sic} to clarify that psychiatrists, psychologists, and other health care provider specialties, for example, physical therapists, may conduct utilization review when appropriate.

Agency Response: TDI clarifies that under §19.1703(a) and §19.2003(a), the words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in the subchapters. The definition of "health care provider" in Insurance Code §4201.002(5) has the same meaning in both Subchapter R and U rules. TDI agrees that the definition of "doctor" in proposed §19.2003(b)(9) tracks the definition of "doctor" in Labor Code §401.011, and, so, TDI clarified in the adopted rules under §19.2003(b)(10) that the definition of doctor in adopted Subchapter U rules is as defined in Labor Code §401.011.

TDI clarifies that, although physical therapists, occupational therapists, and psychologists cannot be "treating doctors" under the Texas Workers' Compensation Act, they can be health care providers, request preauthorization of their services, and dispute an adverse retrospective review of their services. A URA is not precluded from using a properly credentialed physical therapist, occupational therapist, or psychologist to perform utilization review of these services.

Under Insurance Code §4201.153, appropriate non-physician and non-doctor health care providers may issue an adverse determination on a health care service in certain circumstances. However, in accord with Insurance Code §4201.152, all utilization review must still be performed under the supervision of a physician. Additionally, the peer-to-peer discussion requirements under Subchapters R and U require the provider of record to have an opportunity to discuss the determination with a physician. TDI clarifies that under Insurance Code §4201.153, non-doctor, non-physician health care providers must still be appropriate to review the health care services at issue, so those health care providers must still have an appropriate specialty to review the health service and be licensed in Texas or otherwise authorized to provide health care services in Texas when performing utilization review.

Comment: A commenter remains concerned regarding the application of the Labor Code definition of experimental and investigational to health benefit plans as provided in §19.1703(b)(10). The commenter explains that while the legislature adopted a standard definition for the highly regulated workers' compensation program, it did not do so when amending the Utilization Review Act in HB 4290. The commenter asserts that the proposed definition varies from the definition commonly approved by TDI and used in health benefit plan policy form filings. Adoption of this definition by rule will likely require carriers to revise existing approved policy form filings, resulting in new administrative costs for health benefit plans. A commenter recommends leaving this term undefined to avoid potential conflicts with health plan definitions.

A commenter, while not disagreeing with the general nature of this definition in §19.1703(10), requests that TDI allow for definitions used in approved policy forms be an alternative to this definition. The commenter explains that policy forms use more specific definitions of experimental and investigational so as to more clearly delineate acceptable evidence that a procedure is or is not experimental or investigational, thus avoiding disputes between health plans and providers.

Agency Response: TDI disagrees with the suggested changes. TDI clarifies that the definition of the term "experimental or investigational" is at §19.1703(11) in the adopted rules. This definition is consistent with the definition under 28 TAC §12.5(12). It is important that the phrase be defined consistently at the utilization review and independent review stages.

Comment: A commenter states that one provision of the proposed rules could result in the delay of emergent care being rendered to injured employees, who are faced with a medical emergency, by providing for prospective and concurrent review of health care that is proposed to be rendered under emergent or life-threatening conditions. In workers' compensation, a medical emergency precludes the need for preauthorization or concurrent review. Instead, the health care should be rendered, the emergent nature of the delivery of the health care should be documented, and the insurer must then review the health care on a retrospective basis.

A commenter asserts that the definition for "medical emergency" is taken verbatim from Insurance Code §1305.004(a)(13). The commenter notes that the proposed rule therefore applies Chapter 1305, which is only applicable to certified workers' compensation networks, to all workers' compensation entities regardless of network certification status. The commenter asserts this is not what the Legislature intended. Were it otherwise, the Legislature would not have needed to incorporate a separate definition for medical emergency within Insurance Code Chapter 1305, as no potential conflict could exist where neither chapter defines "medical emergency" as in case of conflict, Insurance Code Chapter

1305 controls. The commenter explains that, by making the Insurance Code Chapter 1305 definition of medical emergency applicable to all workers' compensation utilization review, a conflict is introduced. The commenter states that it would be more appropriate to provide that no preauthorization is required for medical emergencies, as both Chapter 1305 and the Act share this standard as it applies to utilization review.

A commenter suggests that psychiatric disturbances and symptoms of substance abuse be added to the definition of medical emergency in §19.2003(b)(20). The commenter points out that psychiatric disturbances and symptoms of substance abuse are specifically included in the definition of medical emergency in the federal regulations that apply to Medicare hospitals, 42 C.F.R. §489.24. The commenter argues that to be complete the definition of medical emergency in these rules should also include these references.

Agency Response: TDI disagrees that a conflict exists with the definition of "medical emergency" in the Insurance Code and the Texas Workers' Compensation Act. As the commenter stated, Insurance Code §1305.004 includes a definition for "medical emergency." The Texas Workers' Compensation Act does not include a definition of "medical emergency;" however, TDI-DWC rules have included a definition of "medical emergency" for many years. The term medical emergency is defined in 28 TAC §133.2 and §134.500, which applies to workers' compensation non-network and network claims, and tracks the definition in Insurance Code §1305.004(a)(13), which is applicable to certified workers' compensation network claims. The term is not new in the workers' compensation system. TDI further clarifies that for both workers' compensation non-network claims and certified workers' compensation network claims, preauthorization is not required for situations that meet the definition of "medical emergencies."

TDI cannot make medical determinations on which specific situations could lead to a medical emergency. The purpose of the adopted rules is to require the URA to have specific procedures for high-risk situations. Additionally, 42 C.F.R. §489.24 specifically applies to the special responsibilities of Medicare hospitals in emergency cases.

Comment: Commenters express concern with the modifier "entire history" in defining medical records. This concern would be allayed by clarification that a URA would not have to request the entire medical record in conducting utilization review, but would only have to request those portions of the medical records pertinent to the service that is subject to the current instance of utilization review.

Agency Response: TDI agrees and has made the suggested change to delete the word "entire" in adopted §19.1703(18) and made a conforming change to adopted §19.2003(19).

Comment: A commenter states that the definition for "medical records" only includes those records pertaining to a compensable injury. However, often injuries that are claimed to be compensable may be non-compensable. The commenter explains that access is necessary to all medical records for both (i) injuries found to be compensable; and (ii) those injuries where compensability either is or could become an issue in dispute. The commenter asserts that this point is particularly true in cases of extent injuries, or injuries or illnesses that could be reasonably attributed to either a workplace injury or natural degeneration, aging, ordinary diseases of life, or accidental trauma that is not work-related.

Agency Response: TDI agrees to make the suggested change because utilization review must be completed even if the injury is non-compensable, and TDI does not want to limit access to relevant records. TDI deletes the word "compensable" in the adopted definition of "medical records" for Subchapter U. TDI further clarifies that adopted §19.2007(b) provides that, when conducting utilization review, a URA must request all relevant and updated information and medical records to complete the review. TDI clarifies that there is a difference between all relevant records and all records. The intent of adopted §19.2007(b) is to prevent the URA from requiring unlimited amounts of medical records from the requestor, some of which may not inform the decision of whether care is medically necessary or appropriate. Additionally, under existing rules, the URA was already required to request the information necessary to complete the review and could only request information relevant to the review.

Comment: Commenters state that the definition of "medical records" could create confusion and lead to withholding of records that must be provided under applicable law. The commenters note that HIPAA, including the provisions under HIPAA applicable to mental health records, is not applicable to workers' compensation and utilization review conducted under workers' compensation. Although Insurance Code §4201.054(c) notes that Labor Code Title 5 prevails in the event of a conflict between that chapter and Labor Code Title 5, it would be preferable not to imply by rule or otherwise that there exists any impediment to utilization review of all records available under Texas workers' compensation law.

Agency Response: TDI declines to expand on the scenarios in which mental health records are permitted to be provided to a URA, and clarifies that Insurance Code §4201.203(a), in part, prohibits a URA from requiring, as a condition of treatment approval or for any other reason, the submission or review of a mental health therapist's process or progress notes.

Comment: A commenter seeks clarification of the purpose of including the phrase "as appropriate" in proposed §19.2003(b)(23). The parameters of what a licensed professional can do are set by the licensing board and, so, need not be included in this definition.

A commenter notes that the words "as appropriate" appear in the introductory paragraph of §19.2003(b)(23) but are not specifically included in subparagraph (H). The commenter explains that physicians licensed by the Texas Medical Board are permitted to "diagnose." Other professionals are not permitted to make a medical diagnosis. This is why, through the relevant licensing statutes, such words do not appear; rather they are permitted to evaluate, assess, and analyze. The word "diagnose" in the "catch all" subparagraph should be struck.

Agency Response: TDI clarifies that the individuals listed under adopted §19.1703(b)(20) and §19.2003(b)(21) are not all qualified to diagnose, evaluate, and treat any mental or emotional condition or disorder. However, the language in this definition provides that a "mental health therapist" is any of the listed individuals who, in the ordinary course of business or professional practice, as appropriate, diagnose, evaluate, or treat any mental or emotional condition or disorder. The language allows for individuals that are only authorized to conduct one or two of those activities. TDI made a clarifying change to subparagraph (H) to add "as appropriate" and made a conforming change to §19.1703(b)(20).

Comment: Commenters assert that the term "payor" in the Subchapter U rules is not appropriate for workers' compensation. The commenters explain that, in the Texas workers' compensation system, the equivalent terms used are "insurance carrier" and "insurance company."

A commenter asserts that the term "payor" is not used in the Texas Workers' Compensation Act but instead is used within group health under the Insurance Code and applicable rules. The commenter notes that Insurance Code §4021.002(10) does not include a workers' compensation insurance carrier as a "Payor." The commenter believes that it is not appropriate that terms not used in the Texas workers' compensation system and not defined in the Labor Code be utilized in or defined by the URA rules. Labor Code §401.011(27) defines "insurance carrier" as an insurance company, a certified self-insurer for workers' compensation insurance, a certified self-insurance group under Chapter 407A, or a governmental entity that self-insures, either individually or collectively. Labor Code §401.011(28) defines "insurance company" as a person authorized and admitted by TDI to do insurance business in this state under a certificate of authority that includes authorization to write workers' compensation insurance. Insurance Code §4201.054(c) provides that in the event of a conflict between Insurance Code Chapter 4201 and the Labor Code, the Labor Code prevails. Thus, any attempt to use a term or apply a requirement from Chapter 4201 of the Insurance Code that conflicts with the Labor Code, for example, the use of the term "payor," is not appropriate given the deference given to the Labor Code. The commenter requests that TDI delete the proposed definition and, instead, include a definition of the term "insurance carrier." The commenter further requests that TDI amend the rule to include the definition of the term "insurance carrier" that is set out in Labor Code §401.011(27).

A commenter asserts that the term "payor" could be interpreted to include third party administrators, pharmacy benefit managers, cost containment vendors, and utilization review agents. In the workers' compensation system, the "payor" is always the insurance carrier or self insured. Third and fourth party vendors who perform services are not and should not be considered "payors."

A commenter objects to the use of the term "payor" as included in the definition for "preauthorization" as this is not a term utilized in the workers' compensation system.

Agency Response: TDI declines to delete the term "payor" in Subchapter U. For clarification, the term includes an insurance carrier or insurer. The statutory definition under Insurance Code §4201.002(10) is not in conflict with Insurance Code Chapter 1305 or Labor Code Title 5. TDI has tailored the definition of "payor" to include a person or entity that provides, offers to provide, or administers workers' compensation benefits, in recognition that the definition of "payor" under Subchapters R and U should not be identical. TDI declines to replace the term "payor" with the term "insurance carrier" or "insurer" in the definitions of "adverse determination" or "preauthorization," because such replacement would result in inconsistent definitions under Subchapters R and U. It is also necessary to retain the references to "payor" because the rules specifically distinguish between insurance carriers for which it is or is not the payor. The term "payor" is also necessary for consistency with the IRO rules under 28 TAC §12.1, which contemplate an IRO's interaction with URAs and payors.

Comment: Commenters assert that the proposed definition of "peer review" is too broad and will capture peer reviews not performed retrospectively to determine medical necessity or appropriateness of health care. Peer reviews may be conducted in workers' compensation for many purposes other than retrospective utilization review. Peer reviews are performed for return to work issues, the appropriateness of experimental healthcare procedures, contribution issues, length of treatment determinations, and other claim related issues. They are not done solely for retrospective utilization review. The commenters assert that the definition of peer review should be limited by specifying that peer review for purposes of these rules is an administrative review by a health care provider regarding the medical necessity or appropriateness of health services performed by a health care provider at the insurance carrier's request without a physical examination of the injured employee.

A commenter expresses concern that the proposed definition of "peer review" limits peer reviews to reviews based on medical necessity. The commenter explains that HB 4290 expanded this to cover a review regarding the experimental or investigational nature of health care services. However, the rule as proposed potentially expands the focus beyond these limitations. The commenter requests that the definition be amended to the following, "An administrative review regarding the medical necessity and/or experimental/investigational nature of health care services requested or performed by a health care provider performed at insurance carrier's request without a physical examination of the injured employee."

A commenter asserts that neither the Insurance Code nor the Labor Code provides the commissioner with the authority to restrict the use of peer reviews to retrospective reviews. The commenter requests that TDI amend the rule by adding, "regarding the medical necessity or appropriateness of health performed" after "an administrative review" in the definition.

A commenter agrees that "peer review" is a component of utilization review and that the rules should be followed; however, the commenter feels that further definition is needed. Typically, when an insurance carrier asks for a peer review/retrospective utilization, review multiple questions are asked including medical necessity, causation, extent of injury, compliance with ODG and MDA to name just a few, along with addressing services that took place over several years.

Agency Response: TDI clarifies that these adopted rules apply to the performance of utilization review and adopted §19.2002(b) specifies that "Health care providers performing peer reviews regarding the prospective, concurrent, or retrospective review of the medical necessity or appropriateness of health care are performing utilization review, must generate a written report, and must comply with this subchapter, Labor Code Title 5, and rules adopted under the Texas Workers' Compensation Act including, but not limited to, Chapter 180 of this title (relating to Monitoring and Enforcement)." This provision and the provisions of Chapter 180 already distinguish between the requirements for peer reviews performed for the evaluation of medical necessity or appropriateness of health care versus peer reviews performed for other issues, such as extent of injury or an injured employee's ability to return to work. Further, having different definitions for the same term in TDI and TDI-DWC rules would create confusion among system participants who are responsible for complying with both the Chapter 180 rules and the workers' compensation utilization review rules.

Comment: A commenter asks whether it was TDI's intent to incorporate "artificial limbs" of individuals with prostheses as part of the "person." The commenter notes that, if this was in fact the intent, then perhaps a better definition would be, "Any person (including his or her prosthetic devices)...."

Agency Response: TDI clarifies that the definition of "person" in adopted Subchapters R and U includes natural persons or entities. TDI amended the definitions of "person" in Subchapters R and U to remove the phrase "natural or artificial person," added the phrase "and any similar entity," and made editorial changes to the definitions of "person" for clarity. A natural person with prostheses would fall under the definition of "person" because he or she is an "individual."

Comment: Commenters express support for the definition of "reasonable opportunity."

A commenter believes that it will benefit patient care and the appropriate interaction of physician and URA. This physician to physician discussion can only benefit communication and, as a direct result, the most efficient clinical treatment of the patient.

A commenter believes that requiring the URA to make a documented, good faith effort to contact the enrollee's provider before issuing an adverse determination benefits consumers by increasing the likelihood that differences of opinion can be reconciled and reducing the need for appeals. The commenter believes that listing reasonable timeframes in which the call to the provider must occur is essential to enable URAs, providers, and TDI to track compliance and increase the likelihood that effective peer-to-peer communication occurs.

Agency Response: TDI appreciates the supportive comments indicating that the definition of "reasonable opportunity" will improve the peer-to-peer discussion process.

Comment: A commenter expresses concern that the requirement under the definition of "reasonable opportunity" to allow at least one business day for a peer-to-peer discussion excessively compresses the URA's timeframe in which to perform its review and could even conflict with the three calendar day timeframe when applicable.

A commenter believes that the provision relating to retrospective review adverse determinations in the definition of the term "reasonable opportunity" should be deleted. The commenter does not think it is appropriate to require a peer-to-peer discussion in the case of a retrospective review. The commenter explains that by the time a retrospective review is conducted, the medical services at issue have already been rendered and only a claim is in dispute, and the rationale for the peer-to-peer requirement does not apply. In addition, in many retrospective claim reviews, for example, hospital claims, it is not evident to the utilization review entity which provider of services should be contacted to offer a peer-to-peer review.

Commenters assert that the five-day requirement for retrospective reviews effectively reduces the prompt pay deadlines imposed by statute.

A commenter notes that a retrospective utilization review is actually a claim review and so the prompt payment requirements will apply to claims and retrospective reviews submitted by network providers. The commenter asserts that utilization review regulations cannot reduce the timeframes provided for claim processing in Insurance Code Chapters 1301 and 843. In fact, Insurance Code §4201.305 specifically provides that the time limits for claim payments in Chapters 1301 and 843 supersede the utilization review timeframes.

A commenter explains that, if in the claim review process it appears that an adverse determination may be necessary, by allowing the provider of record five business days to have an opportunity to discuss the service, the time for complying with the prompt payment period is in effect shorted by this five business day period which, in nearly every instance would be seven or more calendar days, because the only time five business days would not extend over a weekend would be in a case where the attempt to contact the provider is made first thing on a Monday morning. The commenter requests that the times for reasonable opportunity be shorted to take into account the deadline for prompt payment of claims.

A commenter objects to the reasonable opportunity requirement for the provider of record to discuss the plan of treatment with a physician prior to issuing an adverse determination in a retrospective situation. The commenter asserts that, when a service has already been provided, there is no regulatory rationale for providing the opportunity for a peer-to-peer discussion prior to issuing an adverse determination. It would be more cost-effective to require a peer-to-peer consultation for retrospective utilization review only in those instances in which the provider of record makes such a request on receipt of the notice of adverse determination. This solution accomplishes the goal of allowing a peer-to-peer review in those instances in which a provider of record desires such review, without adding unnecessary expense to the process in those instances in which a provider of record may not desire a peer-to-peer review. The commenter urges TDI to revise the rules to require peer-to-peer consultation only in those instances in which the provider of record requests such consultation within a reasonable time of receiving the notice of adverse determination.

A commenter requests that the adoption order clarify that an attempt to contact a provider, which includes an instance where a URA makes such an attempt during regular business hours, but the provider is not available at that moment, and the URA leaves a call back number at which the URA may be contacted to discuss the services under review, constitutes a reasonable opportunity under this definition.

A commenter does not believe a peer-to-peer discussion is appropriate for retrospective review as multiple providers are reviewed over multiple years. A commenter states that this provision has been added to comply with the codes, and anticipates that this provision will not go away regardless of the concerns of physicians. The commenter would like for there to be a clearer indication of who the peer-to-peer discussion should take place with and at what time. When an insurance carrier asks for a peer review (retrospective utilization review) the reviewer gives his opinion at the time he conducts his report, and has no idea what the insurance carrier will do with this information. A commenter asks whether the peer-to-peer discussion only takes place if a medical bill is denied based on the peer review. The commenter asks, when the peer review is being done on a case that has multiple years or multiple reviewers, who is the appropriate party to contact.

A commenter explains that they have no issue with affording the requesting provider a reasonable opportunity. The commenter believes that the term "provider of record" is unclear because the term is not listed in Chapter 180 (relating to Monitoring and Enforcement) or Labor Code §401.011. The commenter suggests

that the term should either be the treating doctor or consulting doctor, as appropriate.

A commenter asserts that one working day is an inadequate time to allow the provider of record to get back to the URA. The commenter requests that the wording of this section be changed to read "no less than three working days. . ."

A commenter asserts that the definition of "reasonable opportunity" exceeds the rulemaking authority of TDI. A commenter asserts that the definition of "reasonable opportunity" is inconsistent with existing statute and other workers' compensation rules.

A commenter asserts that TDI engaged in creative drafting to create the appearance that its proposed rule will not conflict with TDI-DWC rules or with other portions of the Insurance Code.

Commenters assert that the standard of "no less than one working day" conflicts with §134.600(i) and (j) of this title and Insurance Code §1305.353 and §4201.304, which guarantee three working days to make a determination. The statute does not provide for a lesser review period nor does it allow the agency, through rulemaking, to shorten the time. Section 4201.054(c) of the Insurance Code specifically provides that in the event of a conflict between Chapter 4201 and the Texas Workers' Compensation Act (Labor Code, Title 5), the Texas Workers' Compensation Act prevails. The commenters assert that TDI may not shorten the timeframe for making an adverse determination to the "no less than one working day" proposed in the rule.

Commenters assert that this proposed rule effectively shortens the time for making an adverse determination for prospective or concurrent review from three working days to two working days. A commenter explains that the conflict drafted into the definition of "reasonable opportunity" is not necessary and can be eliminated. Commenters recommend, after the phrase "Reasonable opportunity--At least one documented good faith attempt to contact the provider of record," inserting the phrase "that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination." The commenters recommend deleting subparagraphs (A) through (C).

Agency Response: TDI disagrees that the rulemaking authority of TDI is exceeded by defining the term "reasonable opportunity." Existing §19.1711 and §19.2011 already require the URA to afford the health care provider who ordered the services a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis for the URA's decision with a physician or, in the case of a dental plan, with a dentist, prior to issuance of an adverse determination. TDI declines to make the recommended changes to the rule text since the proposed language does not provide any guidance as to what it really means for a URA to provide a "reasonable opportunity" for the provider of record to discuss a potential adverse determination with the URA. TDI further notes that under the commenter's recommended language, a single documented phone call to the provider an hour before issuing an adverse determination would meet the criteria for a "reasonable opportunity," which does not align with the legislative intent behind this requirement to facilitate communication between URAs and health care providers to avoid unnecessary denials.

TDI clarifies that the notification of the adverse determination for workers' compensation non-network coverage must be provided within the timeframes specified by 28 TAC §134.600. Section 134.600(i) requires a decision for preauthorization requests within three working days and a decision for certain requests for concurrent review within one working day of the receipt of the request.

The notification of the adverse determination for workers' compensation network coverage must be provided within the timeframes specified by Insurance Code §1305.353 and 28 TAC §10.102.

Under Insurance Code §1305.353(d), the URA must generally issue a determination on a preauthorization request not later than the third working day after the receipt of the request. However, under Insurance Code §1305.353(e), if the proposed services are for concurrent hospitalization care, the URA must transmit a determination within 24 hours of receipt of the request.

Under Insurance Code §1305.353(f), if the proposed health care services involve post-stabilization treatment or a life-threatening condition, the URA must transmit a determination within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, not to exceed one hour from receipt of the request. Title 28 TAC §10.102 reiterates these statutory requirements.

Based on these timeframes, a URA must issue a determination for request for prospective review no later than the third working day after receipt. This three-working day timeframe is compatible with the requirement that the provider of record be afforded no less than one working day to discuss the determination.

Insurance Code §4201.206 provides that, subject to certain notice requirements, before an adverse determination is issued by a URA that questions a health care service on the basis of medical necessity or appropriateness or the experimental or investigational nature of the service, the URA must provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination.

TDI declines to delete the peer-to-peer requirement for retrospective reviews or to amend the requirement that a good faith opportunity includes no less than five working days prior to issuing a retrospective review adverse determination. As previously discussed, HB 4290 amends the definition of the term "utilization review" in §4201.002(13) of the Insurance Code to specifically include "retrospective review." The Insurance Code §4201.206 provides that, subject to the notice requirements of Subchapter G of Chapter 4201, before an adverse determination is issued by a URA who questions a health care service on the basis of medical necessity or appropriateness or the experimental or investigational nature of the service, the URA must provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination.

Because "utilization review agent," means "an entity that conducts utilization review . . ." under Insurance Code §4201.002, and the term "utilization review" includes "retrospective review" under Insurance Code §4201.002(13), the requirements in §4201.206 apply to URAs conducting retrospective review.

Under Insurance Code §4201.305, the URA must provide notice of a retrospective review adverse determination within a reasonable time, but not later than 30 days after the date on which the claim is received. Under Insurance Code §4201.305(b), this period may be extended once for a period not to exceed 15 days, if the URA takes certain additional steps. Because of the longer time granted to URAs to issue determinations when conducting

retrospective utilization review, TDI finds that five working days is a reasonable amount of time to afford the provider of record to discuss the determination.

TDI disagrees that compliance with the reasonable opportunity requirement will create additional difficulty for plans to comply with prompt pay requirements. None of the timeframes are incompatible with prompt pay deadlines, such that providing the reasonable opportunity will result in non-compliance with these deadlines.

Insurance Code §4201.206 requires a reasonable opportunity, and TDI asserts that further defining parameters for what constitutes a "reasonable opportunity" will assist in ensuring such an opportunity is actually afforded to the provider of record. The definition, as revised, does not cause any conflict with existing timeframes for decisions.

TDI clarifies that the provider of record is entitled to a reasonable opportunity, as defined in §19.1703(b)(26) and §19.2003(28), to speak to a physician or doctor before an adverse determination is issued by a URA who questions the necessity or appropriateness, or the experimental or investigational nature, of a health care service. Insurance Code §4201.206 specifically requires an opportunity for the requesting provider to speak with a physician.

In response to the question on the appropriate party to contact, TDI clarifies that the provider of record, as defined in Insurance Code §4201.002(12), must be given the reasonable opportunity to speak to a physician or doctor.

In response to the comment that one working day is inadequate to allow the provider of record to respond to the URA, TDI declines to require additional days. TDI has to consider not only the interest of the provider of record in having a reasonable opportunity to discuss the determination, but also the interest of the URA in rendering a timely decision and having sufficient time to do so.

Comment: A commenter asserts that the inclusion of a definition for and use of the term "provider of record" is not appropriate, is misleading, and is potentially confusing as the term does not appear in the Texas Workers' Compensation Act. In workers' compensation the applicable term would instead be referred to as "treating doctor." An appropriate expansion might entail including treating doctor with "or the healthcare provider requesting services or review."

A commenter notes that while "provider of record" may be applicable to general health, the term "provider of record" is not used in workers' compensation medical services. The commenter asserts the term is unnecessary, creates the potential for confusion, and should be withdrawn.

A commenter requests that TDI either consider replacing "provider of record" with "requestor" or add the definition for "requestor."

A commenter asserts that Chapter 180 relating to Monitoring and Enforcement and Labor Code §401.011 do not include the term "provider of record." The commenter believes this term confuses the system in which the treating doctor is the doctor primarily responsible for the efficient management of health care with coordinating health care for an injured employee's compensable injury as outlined in Chapter 180.

Agency Response: TDI declines to make the suggested change. The provider of record is the individual requesting treatment on behalf of the injured employee and is the point of contact for the URA to discuss a pending adverse determination, request records, and provide notice of favorable or adverse determinations. The provider of record could be the treating doctor or requestor.

This definition of "provider of record" mirrors the definition in Subchapter R and is necessary to track Insurance Code §4201.002(12), which defines "provider of record" as the physician or other health care provider with primary responsibility for the care, treatment, and services provided to an enrollee. The term includes a health care facility if treatment is provided on an inpatient or outpatient basis. Insurance Code Chapter 4201, to the extent not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305, applies to workers' compensation utilization review. Insurance Code §4201.003(a) grants the commissioner general rulemaking authority to implement Insurance Code Chapter 4201. TDI asserts that there is no direct conflict with the use of "provider of record" and Labor Code Title 5. TDI has the rulemaking authority to define and utilize the term "provider of record" throughout the Subchapter U rules.

Comment: Commenters assert that the definition of "retrospective utilization review" should include the requirement that the review be for purposes of determining medical necessity or appropriateness.

A commenter asserts that the definition of "retrospective utilization review" should include the requirement that the review be for purposes of determining medical necessity or the experimental or investigational nature of the health care services that have been provided to the injured employee.

Agency Response: TDI declines to make the suggested change. The definition of the term "utilization review" in Insurance Code §4201.002(13) includes medical necessity and appropriateness, as well as the experimental or investigational nature of a health care service. The words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in Subchapters R and U, so inclusion of the phrase would be redundant.

Comment: A commenter asserts that the definition of the term "screening criteria" conflicts with the description of screening criteria in §19.2005(c), regarding general standards of utilization review, which is much more appropriate and includes a requirement that the screening criteria must be evidence-based, scientifically valid, outcome-based, and in compliance with the requirements in Section 4201 of the Insurance Code. The commenter requests that TDI delete the phrase "such as appropriateness evaluation protocol (AEP) and intensity of service; severity of illness; discharge; or appropriateness screens (ISD-A)."

The commenter further requests TDI add "must be evidence-based, scientifically valid, outcome-focused, and that comply with the requirements in Insurance Code §4201.153" to the definition of "screening criteria." The screening criteria must also comply with §19.2005(c) of this title (relating to General Standards for Utilization Review and Retrospective Review)."

Agency Response: TDI declines to make the suggested deletion because this language does not appear in the proposal and no deletion is required. TDI declines to add the language "must be evidence-based, scientifically valid, outcome-focused, and that comply with the requirements in Insurance Code §4201.153" to the definition of "screening criteria" because this language is already in adopted §19.2005(c) and §19.1705(c), and inclusion of the same phrase in the definition would be redundant and unnecessary. TDI declines to add language requiring compliance

with §19.2005(c) in the definition of "screening criteria," because compliance with the rules is already required, and inclusion of the phrase in the definition would not add any clarity.

Comment: A commenter asserts that the term "health plan" is a group health insurance term. The commenter recommends that the term "workers' compensation health plan" be deleted and replaced with the term "workers' compensation political subdivision health care networks" with the same proposed definition.

Agency Response: TDI declines to make the suggested deletion. The term "health plan" is used in rules applicable to workers' compensation in 28 TAC §110.7(a), which defines "health plan" as a political subdivision contracting with health care providers under Labor Code §504.053(b)(2). TDI clarifies that the term is necessary to harmonize these rules with other TDI-DWC rules.

§19.1704 and §19.2004. Certification or Registration of URAs.

Comment: A commenter requests, for purposes of clarity and completeness, that the statutory sections that differentiate between certification and registration be referenced in the rule itself. Therefore, Insurance Code §4201.057 and §4201.058 should be cited in the initial wording of subsection (a) of section 19.1704.

Agency Response: TDI agrees with the commenter's suggested change and added "§§4201.057, 4201.058, and 4201.101" to §19.1704(a) and made a conforming change to §19.2004(a).

Comment: A commenter asserts that the requirement for workers' compensation carriers to register as URAs when the workers' compensation carrier only performs utilization review for coverage for which it is the "payor" exceeds the requirements of Chapter 4201, and raises the issue of whether this provision may be beyond the authority of TDI to promulgate. The applicable statutory provisions requiring registration only speak to "other than a person or entity for which the insurer is the payor." Furthermore, the statutory requirement is for a "certificate of registration" and does not split the requirement for registration and certification into two requirements as the rule proposal does. Certificates of registration are only required under Chapter 4201 for URAs or HMOs performing utilization review for persons or entities other than a person or entity for which the HMO is the payor. The only time registration should otherwise be required is when a workers' compensation carrier is certified as a network under Chapter 1305. With respect to the state program, the office does not issue a policy, plan, or contract to provide coverage as coverage is provided as a statutory requirement; the office cannot in any event qualify as a "payor" and thus has no need to register as a URA.

Agency Response: TDI changed the definition of "payor" to include the words "or statute" to clarify that the term applies to the State Office of Risk Management. Under Insurance Code §4201.054(c), Labor Code Title 5 prevails in the event of a conflict between Insurance Code Chapter 4201 and Labor Code Title 5. Insurance Code Chapter 4201 applies to workers' compensation utilization review. Labor Code Chapter 412 provides that the state is self-insuring with respect to an employee's compensable injury. Labor Code §501.021 provides that an employee with a compensable injury is entitled to compensation by the director as provided by Chapter 501. Labor Code §501.001(3) provides that "director" means the director of the State Office of Risk Management. Labor Code §501.002(a) provides that Labor Code §401.011 and §451.001 apply to and are included in Labor Code Chapter 501, except to the extent that they are inconsistent with Labor Code Chapter 501. Section 501.002(c) provides that, for purposes of applying the provisions listed by Subsection (a) to this chapter, "insurer" means "state," "office," "director," or "state agency," as applicable.

Comment: A commenter expresses concern with the requirement that an applicant correct the omissions or deficiencies in the application, or request additional time in writing, within 15 working days of the date of TDI's latest notice of omissions or deficiencies. The commenter notes that the existing rule provides that the applicant must correct the omissions or deficiencies in the application within 30 days of the date of TDI's latest notice of such omissions or deficiencies. The commenter asserts that the proposed 15-day requirement to submit corrections to the URA application does not provide an applicant with adequate time to gather any omitted information and to correct deficiencies found by TDI staff. The commenter asserts that the stated reason for the reduction from 30 days to 15 days does not make sense because URAs do not provide services or products to Texas consumers. URAs provide utilization review services to insurance carriers and certified self-insured employers. As such, Texas consumers derive no benefit from the current 30-day timeframe being reduced to 15 days. The commenter requests that the existing 30-day timeframe for submitting application corrections to TDI not be changed.

A commenter appreciates that the 15-day deadline is working rather than calendar days. The commenter prefers the 30-day response time currently required by the rules. The commenter also notes that deficiency letters from TDI were received that provide only 10 days to respond under Insurance Code §38.001.

Agency Response: TDI declines to make the requested change. As stated in the proposal, this proposed reduction in time to correct the omissions or deficiencies is necessary to streamline the application process, providing TDI with information more quickly. Making more URAs more quickly available allows the provider or claimant to have access to a more efficient administrative process coordinated by TDI. Also, §19.2004(f) allows the applicant to request extra time in writing, and TDI will grant an extension as warranted.

Under adopted §19.1704(f) and §19.2004(f), applicants have 15 working days from the date of TDI's latest notice of omissions or deficiencies in the application. Insurance Code §38.001(b), in part, provides that TDI may address a reasonable inquiry to a holder of an authorization relating to the person's business condition or any matter connected with the person's transactions that TDI considers necessary for the public good or for the proper discharge of TDI's duties. Insurance Code §38.001(c) further provides that a person receiving an inquiry under Subsection (b) must respond to the inquiry in writing not later than the 10th day after the date the inquiry is received.

Comment: A commenter believes it is more reasonable to wait until the license renewal to file revisions and application updates required by §19.1704(j) because URAs must renew licenses every two years. The commenter also believes this approach would avoid all licensed entities filing with TDI at one time and result in a more efficient allocation of TDI resources.

A commenter objects to the requirement that currently certified or registered URAs submit updated applications to TDI within 90 days of the effective date of this rule in §19.1704(j). Currently certified or registered URAs are legally bound to comply with all regulatory requirements and TDI has the ability to enforce these regulations on becoming aware of non-compliance through complaints or other avenues. The exercise of filing updated applica-

tions to illustrate compliance is costly, both to URAs and TDI, and is unnecessary. The commenter recommends that this requirement be deleted.

Agency Response: TDI declines to delete the effective date from the rule. TDI, as explained in the reasoned justification, has determined that the effective date of the adopted rules, which gives stakeholders 90 days to comply from the date the adoption order is filed with the Secretary of State, is sufficient. Based on this effective date, TDI also clarifies that existing URAs have an obligation to update their applications, but their submission of updated information does not change their existing renewal date. §19.1705 and §19.2005. General Standards of Utilization Review.

Comment: A commenter asserts that §19.1705 has been severely amended to remove many of the specific requirements placed on utilization review agents and the required plan. The result is that the plan is given general direction and no specifics. The result is that the ability of TDI to enforce any provisions, or lack thereof, is also severely limited. The commenter suggests that most, if not all, of the current rule be retained.

Agency Response: TDI clarifies that the components listed in existing §19.1705(1) - (3) and §19.2005(1) - (3) to be included in the utilization review plan are not included in the proposed new sections because TDI proposes updated required components in subsections (b) - (f) of §19.1705 and §19.2005 or the components are otherwise incorporated into other sections, and the retention of the provisions would be repetitive.

For example, requirements in the introductory paragraph of existing rules, regarding the utilization review plan, are retained in Insurance Code §4201.151. Requirements in existing §19.1705(2)(A) are retained in Insurance Code §4201.153(b), regarding special circumstances. Requirements in existing §19.1705(2)(B) are retained in adopted §19.1709(a). Requirements in existing §19.1705(2)(C) are retained in §19.1711, regarding Written Procedures for Appeal of Adverse Determinations, and Form LHL005 requires submission of template letters. Requirements in existing §19.1705(2)(D) are retained in adopted §19.1712, regarding URA's Telephone Access.

Comment: A commenter asserts that §19.2005(b) should be stricken as it is inconsistent with the Texas Workers' Compensation Act and is beyond TDI's rulemaking authority. The commenter explains that the purpose of utilization review is to review health care services or proposed health care services to determine whether the services are in line with the Texas Workers' Compensation Act's requirement that the health care be reasonably required by the nature of the injury under Labor Code §408.021. Health care is reasonably required if the services are "clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence-based medicine or if that evidence is not available, generally accepted standards of medical practice recognized in the medical community" under Labor Code §401.011(22a).

Commenters assert that §19.2005(b) is inappropriate for rules applicable to workers' compensation health care. Commenters assert that §19.2005(b) should be deleted in its entirety. There are only two "special circumstances" identified in the Texas Workers' Compensation Act that potentially impact the timing of utilization review services. The first is "emergency" medical treatment which is exempt from preauthorization and concurrent review under Labor Code §413.014 and Insurance Code §1305.351, as well as 28 TAC §134.600. The second "special circumstance" applies to serious bodily injuries sustained by first responders who are employed by political subdivisions under Labor Code §504.055. The commenters assert that §19.2005(b) is not needed because "emergency treatment" is only subject to retrospective medical utilization review and because the "special circumstance" related to first responders is dealt with in §19.2005(g).

Commenters assert that there are no other "special circumstances" found in the Texas Workers' Compensation Act. Neither the Insurance Code nor the Labor Code provide TDI with rulemaking authority to create additional "special circumstances" applicable to the review of workers' compensation health care. Such a rule conflicts with the clear language of the Labor Code. In addition, the use of the terms "acute condition," "disability," and "life-threatening illness" are inappropriate for the workers' compensation rules and are unnecessary. The term "disability" is defined in Labor Code §401.011(16) as the inability because of a compensable injury to obtain and retain employment at wages equivalent to the pre-injury wage. The term is relevant to the entitlement to income benefits but is not relevant to the entitlement to medical benefits.

A commenter asserts that §19.2005(b) is not needed since the "special circumstance" related to first responders is dealt with in other sections of the proposed rules.

Commenters state that the term "life-threatening" is borrowed from statutory requirements for health insurance and health benefit plans. The Texas Workers' Compensation Act does not use that term but instead utilizes the term "emergency," which has broader meaning and application. Commenters note that the term "life-threatening" is not included in any section of the Act. The use of the term "life-threatening" in a TDI-DWC rule is inappropriate and could lead to confusion among the system stakeholders.

A commenter reminds TDI staff that Insurance Code §4201.054(c) specifically provides that in the event of a conflict between Chapter 4201 of the Insurance Code and the Labor Code, the Texas Workers' Compensation Act prevails. The commenter asserts that any attempt to use a term or apply a requirement from Chapter 4201 or TDI rules that conflicts with the Texas Workers' Compensation Act and TDI-DWC rules, is not appropriate given the deference to the Texas Workers' Compensation Act. The commenter requests that §19.2005(b) be deleted.

A commenter explains that medical conditions requiring emergency services include life-threatening illnesses. These are not separate concepts that can be handled with conflicting regulations. The commenter further asserts that life-threatening illnesses requiring emergency services are exempt from prospective and concurrent utilization review. However, these proposed rules consistently state that life-threatening illnesses that require emergency treatment require immediate prospective and concurrent utilization review and an immediate appeal to an IRO. The commenter states this is wrong and is dangerous for workers with life-threatening conditions and health care providers rendering treatment.

A commenter states that since the term "disability" is not going to have the commonly understood definition, this rule should provide a definition of the term to ensure that all system participants have the same understanding of its meaning.

A commenter asserts that §19.2005(b) lists examples of special circumstances a utilization review must consider that may require deviation from the norm stated in the screening criteria or relevant guidelines. However, the given examples appear to be in general unrelated to the treatment of the compensable injury. In workers' compensation, utilization review should properly consider special circumstances to devise a treatment plan to treat a compensable injury and return the employee back to work that will not aggravate, exacerbate, or otherwise harm the patient.

Agency Response: TDI declines to make the suggested deletion. TDI clarifies that these are requirements under existing §19.1705(2)(A) and §19.2005(2)(A), which have been in place for years and have not caused confusion or created problems for URAs during that time.

Section 19.1705(b) and §19.2005(b) provide some specific examples in association with the statutorily imposed general standard of utilization review relating to special circumstances. Insurance Code §4201.153 requires the utilization review determination to take into account special circumstances of each case that may require deviation from the norm stated in the screening criteria or relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness. This requirement is consistent with Insurance Code §4201.153.

The clarifying sentence, "Disability shall not be construed to mean an injured employee who is off work or receiving income benefits" is sufficient. As stated in the proposal preamble, in establishing general standards for utilization review, the language in §19.2005(b) distinguishes the term "disability" as it is used in general medical environments from how the term is used in the Texas workers' compensation system. The term "disability" as used in this section should not be confused with the Texas Workers' Compensation Act's definition of "disability." Labor Code §401.011(16) defines "disability" as "the inability because of a compensable injury to obtain and retain employment at wages equivalent to the pre-injury wage." Additionally, Labor Code §401.011(23) defines "impairment" as "any anatomic or functional abnormality or loss existing after maximum medical improvement that results from a compensable injury and is reasonably presumed to be permanent." Utilization review is solely for the purpose of determining the medical necessity and appropriateness of health care services. The ability to retain employment or the determination of medical maximum improvement has no relevance in the utilization review process.

TDI and TDI-DWC disagree that the terms as used in this rule are inappropriate. As previously discussed in the agency response to general comments regarding the use of the term "life-threatening" in Subchapter R, the concept of "life-threatening" conditions is already introduced in the workers' compensation system. TDI and TDI-DWC agree that Labor Code §413.014, Insurance Code §1305.351, and 28 TAC §134.600 exempt emergency treatment and services from prospective and concurrent utilization review, but it is not TDI and TDI-DWC's intent to apply the requirements regarding life-threatening conditions to emergency treatment. The terms "life-threatening condition" and "emergency treatment" are not the same. "Life-threatening" is an existing term that is defined in Insurance Code §4201.002 and 28 TAC §12.5 and §133.305. "Emergency care" and "emergency" are defined in Insurance Code §4201.002 and 28 TAC §133.2, respectively. These terms have been used without any noted disruption or confusion reported to the TDI-DWC by system participants.

Comment: A commenter asserts that the requirement in the second sentence of §19.1705(c) that, if evidence based medicine is not available for a particular health care service, the URA must use "generally accepted standards of medical practice recognized in the medical community" is vague at best. The commenter suggests that the provision simply reference the statute, as it does in the first sentence, and delete this second sentence.

A commenter asserts that such terms as "evidence-based," "scientifically valid," and "outcome-focused" are requirements that are used in the regulation of workers' compensation networks when selecting a guideline to be used only in workers' compensation utilization review under Labor Code §413.011(e). To use the requirements for selecting a workers' compensation guideline for the screening criteria in §19.2005(c) is inappropriate. Screening criteria and guidelines are not interchangeable and do not denote the same requirements or usage. Insurance Code §4201.153 does not mention "evidence-based" and "scientifically valid" is not used. Rather, the words "clinically valid" are used and denote a different type of review. The commenter asserts that the attempt to blend the selection of guidelines, used for maximum medical improvement, and not for precertification or concurrent review, and workers' compensation screening criteria, is an inappropriate and confusing mix of the two types of review.

A commenter notes that the language of the rule appears to require URAs to permit either evidence-based or community-based medicine if evidence-based medicine is not available for the service: an either or proposition. However, the commenter asserts that the standard incorporated into Labor Code 401.011(22-a) is not an either or type proposition. It is more stringent in its overarching requirement that the health care be both clinically appropriate and considered effective for the injured employee's injury.

Agency Response: TDI declines to make the suggested change. Insurance Code §4201.153(a) - (c) imposes three requirements. First, a URA must use written medically acceptable screening criteria and review procedures that are established, periodically evaluated, and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers. Second, a utilization review determination must be made in accord with currently accepted medical or health care practices, taking into account special circumstances of the case that may require deviation from the norm stated in the screening criteria. Third, screening criteria must be: (1) objective; (2) clinically valid; (3) compatible with established principles of health care; and (4) flexible enough to allow a deviation from the norm when justified on a case-by-case basis.

Also, proposed §19.1705(c) requires screening criteria to recognize that if evidence-based medicine is not available for a particular health care service provided, the URA must utilize generally accepted standards of medical practice recognized in the medical community. This provision recognizes that evidence-based medicine will not always be available. This provision is necessary to harmonize the Subchapter R screening criteria requirements with proposed §19.2005(c), which incorporates the Labor Code requirements. Under the commissioner's authority in §4201.003 to adopt rules to implement Chapter 4201, TDI determined this conforming change to be necessary in Subchapter R rules to implement the existing requirements for screening criteria in accord with §4201.153 while keeping screening criteria standards that are consistent with those under Subchapter U.

TDI disagrees that adopted §19.2005(c) provides a different standard than Labor Code §401.011(22-a) for the use of evidence-based medicine. Labor Code §401.011(22-a) provides that the term "health care reasonably required" means health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accord with best practices consistent with: (A) evidence-based medicine; and (B) if that evidence is not available, generally accepted standards of medical practice recognized in the medical community.

Comment: A commenter supports screening criteria requirements in §19.1705(c) and §19.2005(c).

Agency Response: TDI appreciates the supportive comment.

Comment: A commenter notes that standard utilization management practices on a national level allow for initial preauthorization and or concurrent utilization review requests be determined by a physician, or other health care provider. For example if a request comes in from an M.D. then another M.D. could conduct the review; likewise, if a request comes in from a D.C., an M.D. could also conduct the review, however, a D.C. could not review a request from an M.D. as the M.D. has more medical training. The requirement for like-to-like specialty only comes into play when a second level review or appeal is requested. The commenter asks whether §19.2005(d) is saying an M.D. cannot review a request from a D.C. The commenter also asks whether §19.2005(d) is saying that M.D. to M.D. never plays a role and that at all times we have to consider like-to-like specialty.

Agency Response: TDI clarifies that a doctor performing a peer review for the review of medical necessity or appropriateness of care of a specific workers' compensation case must hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving, as required under Labor Code §408.0043. The reference in adopted §19.2005(d) to Labor Code §§408.0043 - 408.0045, is to clarify that physicians and doctors performing utilization review must also comply with the Labor Code. In addition, a doctor performing a peer review for medical necessity or appropriateness of care of a specific workers' compensation case must also hold the "appropriate credentials" as defined by 28 TAC §180.1.

Comment: A commenter asserts that the language in §19.2005(e) should be corrected to reflect that the delegation is to hospitals or other health care facilities. If the section is intended to merely describe the person who may perform the utilization review for the hospital, and omit other health care facilities in the rule, the rule should be amended to reflect that they are part of the "qualified personnel" at the hospital that may perform such review for the hospital.

A commenter explains that Insurance Code §4201.251 permits delegation to personnel at the hospital or other health care facility, not to "qualified health care providers." The statute establishes a limited set of delegates and "qualified health care providers" are not contained within the statute. The commenter asserts that the proposed additional language in §19.1705(e) goes beyond the authority set in statute. The language should be corrected to reflect that the delegation is to hospitals or other health care facilities.

Agency Response: TDI agrees to make the suggested change to more closely track Insurance Code §4201.251. TDI inserted the word "utilization" before the term "review" and deleted the phrases "utilization review program," and "a qualified health care provider." TDI replaced the deleted phrases with "other health care facility in which the health care services to be reviewed were, or are, to be provided."

Comment: A commenter asserts that §19.1705 (f) should be amended to reflect that a complaint system includes an appeal process. The appeal process is an important part of a fair process and is required by Insurance Code §4201.303(a)(4). The appeal process, at a minimum, can be incorporated by reference to §19.1709(b)(6) and §19.1711.

A commenter asserts that any complaint system must have a mechanism for appeal. The requirement here is no different. The ability to have a viable and robust complaint and appeal mechanism will help injured workers', their representatives, or health care providers better access the system and provide facts and information necessary for a full and fair presentation of the injured worker's issues.

Agency Response: TDI disagrees that Insurance Code §4201.303(a)(4) requires a URA's complaint system to include an appeal process. Insurance Code Chapter 4201, Subchapter H, provides the requirements for an appeal process for appealing an adverse determination, §4201.2352 requires the URA to maintain and make available the written procedures for appealing an adverse determination, and §4201.303(a)(4) requires the description of the procedure for the appeal process be included in the notice of an adverse determination. Insurance Code §4201.204, regarding complaint system, outlines the requirements for a URA's complaint system and does not include a requirement for a complaint appeal process. Insurance Code §4201.351 provides that a complaint concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination. An individual may file a complaint with TDI after filing a complaint with the URA. Adopted §19.1705(f) requires the URA to include with their written response to the complainant TDI's address, toll-free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI.

Comment: A commenter asserts that in regard to §19.2005(f), the complaint system should include complaints filed by a person acting on the injured worker's behalf. The commenter knows of no reason to restrict the ability to complain to representatives and to exclude others acting on behalf of the injured worker.

Agency Response: TDI disagrees with adding the commenter's suggested language to adopted §19.2005(f) because that subsection is consistent with existing TDI-DWC rules in Chapter 150 which govern representation of parties before the agency and qualifications of the representatives.

Comment: A commenter asserts that they agree that first responders who sustain a serious bodily injury be given priority; however, the commenter does not understand how this can be part of the URA's responsibility in §19.2005(g). The commenter asserts that emergency care for workers' compensation does not require preauthorization. The commenter states that, depending on how the carrier has their account set up with the URA, the URA has to rely on the insurance carrier to notify them of a requested service. The commenter asks if the carrier has the requested utilization review for any length of time prior to providing it to the URA, how the URA can be held responsible for their actions.

Agency Response: TDI clarifies that §19.2005(g) requires URAs to include in their written policies evidence that the URA's policies are in compliance with Labor Code §504.055, but is not intended to hold URAs responsible for an insurance carrier's fail-

ure to comply with the law. Labor Code §504.055 requires, in part, that the political subdivision, division, and insurance carrier accelerate and give priority to an injured first responder's claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury described by Labor Code §504.055(b).

§19.1706 and §19.2006. Requirements and Prohibitions Relating to Personnel.

Comment: A commenter recommends amendment to the licensure requirements for utilization review personnel under §19.1706 and §19.2006. In both sections, while physician utilization review agents are required to be licensed as a physician in the United States, the proposed rules do not require Texas physician licensure. The commenter strongly supports amending the proposed rules so that they are consistent with the proposed language of §19.2006 that requires Texas physician licensure. The commenter asserts that utilization review performed by physicians cannot help but require physicians to exercise medical judgment that has a direct impact on patient care. Texas Medical Board rule 22 TAC §190.8(1)(E) adopted in November 2003, provides that a Texas physician may be disciplined by the Texas Medical Board for failure to practice in an acceptable manner consistent with public health and welfare within the meaning of the Act, including failure to perform proper utilization review. The commenter believes the rule is consistent with Insurance Code §4201.002(13) that defines "utilization review" as the "review of the medical necessity and appropriateness of health care services." The commenter explains that requiring physician utilization review agents to be licensed, without requiring Texas licensure, renders the requirement irrelevant.

The commenter explains that the Texas Medical Board is charged with protecting public health and welfare through the regulation of the practice of medicine. This includes giving Texas patients the ability to exercise their right to file complaints with the Texas Medical Board against physicians that fail to meet the standard of care. If physician utilization review agents are not licensed in Texas, the physicians will be insulated from the Texas Medical Board, and any action that TDI might take against an insurer or utilization review agent will very likely have no affect on a physician's licensure in another state. While TDI's proposed rules require that physician URAs have current and unrestricted licenses in any state, this is not a difficult requirement to meet or maintain. In the case of a URA physician not licensed in Texas that is disciplined by TDI, that physician's out-of-state licensing boards are likely to never be put on notice of the physician's out-of-state violation of the standard of care, and even if they were, it would be unlikely for them to take action without the Texas Medical Board first taking action, when their own state's residents are unaffected. As a result, the Texas Medical Board could not take necessary corrective action against a physician unlicensed in Texas and disciplined by TDI based on findings that the physician has deficiencies in medical knowledge, which would seriously weaken the Texas Medical Board's ability to protect the public. If the intent is to ensure that the physicians have the requisite medical knowledge to perform utilization review, TDI could just require board certification by the American Board of Medical Specialties or the Bureau of Osteopathic Specialists. However, requiring licensure means requiring that the physicians be held accountable not only to TDI, but to medical licensing authorities where the medical treatment is provided, namely Texas.

The commenter requests that the proposed rules be amended to be consistent with the proposed language of §19.2006, which requires that a URA for workers' compensation coverage be licensed in Texas.

Agency Response: TDI made clarifying changes to add the following paragraph to §19.1706(a), "(1) This subchapter does not supersede requirements in the Medical Practice Act, Texas Medical Board rules, Texas Occupations Code Chapter 201 (relating to Chiropractors), or Texas Board of Chiropractic Examiners rules. Individuals licensed by the Texas Medical Board are subject to Title 22 TAC Chapter 190, regarding disciplinary guidelines."

TDI clarifies that adopted §19.1706 and §19.1716 are not meant to be in conflict with the Medical Practice Act or Texas Medical Board rules. Section 19.1706(a) requires personnel conducting utilization review to hold an unrestricted license, administrative license, or to be otherwise authorized to provide health care by a licensing agency in the United States, consistent with Insurance Code §4201.252(a). This new section was unanimously recommended by the Utilization Review Advisory Committee.

Comment: A commenter asks if TDI will identify what appropriately trained and qualified is under §19.1706(a) and §19.2006(a). The commenter asks, if a provider is currently licensed, this in itself shows that they are appropriately trained and qualified as the medical board has continued to issue licensure.

Agency Response: TDI clarifies that adopted §19.1706(a) and §19.2006(a) already address licensure requirements. Adopted §19.1706(a) and §19.2006(a) require personnel conducting utilization review to hold an unrestricted license or an administrative license in or be otherwise authorized to provide health care services by a licensing agency in the United States, and Texas, respectively. Insurance Code §4201.152 requires a URA to conduct utilization review under the direction of a physician licensed to practice medicine by a state licensing agency in the United States. Adopted §19.2006(a) also requires physicians and doctors conducting utilization review to hold a professional certification in a health care specialty appropriate to the type of health care the injured employee is receiving as required by Labor Code §§408.0043, 408.0044, and 408.0045. Physicians, doctors, and other health care providers conducting utilization review must have the appropriate credentials as required by Chapter 180 of this title (relating to Monitoring and Enforcement). Adopted §19.2006(e) requires that the URA's utilization review be under the direction of a physician currently licensed without restriction to practice medicine in Texas.

Comment: A commenter asserts that the qualification requirements in proposed §19.2006(a) go beyond the statutory requirements and rulemaking authority of TDI. The commenter asserts that the proposed rule violates Labor Code §408.0231(g) and §413.014(f). Insurance Code §4201.054(c) expressly requires the Labor Code provisions to prevail over the Insurance Code provisions. This proposed rule clearly violates the "in state" provisions of Labor Code §408.0231(g), which expressly states, in relevant part, "A doctor who performs peer review under this subtitle must hold the appropriate professional license issued by this state . . ." This statutory in-state licensure requirement applies to "doctors" and does not apply to all personnel conducting utilization review. In addition, the qualification requirements do not apply to all forms of utilization review.

The commenter states that the clear thrust of Labor Code §413.014(f) is that the legislature does not want TDI-DWC to interfere with the voluntary discussions between the carrier and health care providers regarding health care treatment and plans "either prospectively or concurrently" and likewise should not prohibit or restrict the carrier ". . . from certifying or agreeing to pay for health care consistent with those agreements." There is no statutory authority to justify applying these requirements to personnel or nurses who certify or agree to pay for health care on behalf of the carrier. These qualification requirements only have applicability to "adverse determinations" and not to utilization reviews that lead to voluntary certification or agreement to pay for health care services. The commenter recommends replacing the phrase "to perform utilization review" with the phrase "who render adverse determinations." The commenter recommends deleting the phrase "Personnel conducting utilization review" and replacing the phrase with "Doctors rendering adverse determinations."

Agency Response: TDI declines to make the suggested changes. Requiring all personnel performing utilization review of workers' compensation services to be licensed in Texas or be otherwise authorized to provide health care services in Texas is consistent with the objectives of Labor Code §408.023(h) and House Bill 1006, 80th Legislature, Regular Session, effective September 1, 2007. The requirement is necessary to ensure that appropriate health care providers, in accord with Insurance Code §4201.153(d), are used to determine medical necessity. TDI has rulemaking authority under Insurance Code §4201.003 and §36.001 to adopt this requirement.

TDI clarifies, however, that this licensing requirement only applies to personnel performing utilization review of workers' compensation services under the Insurance Code Chapter 4201, not all personnel involved in a URA's utilization review operations.

Comment: A commenter appreciates the introductory discussion's acknowledgement in §19.1706(a) that the personnel conducting utilization review activities for nonworkers' compensation plans are required to hold a license issued by "a" state license board and that a Texas Medical Board license is required for workers' compensation utilization review activities only. The commenter requests including an acknowledgement that a Texas Medical Board license is not required for utilization review activities, unless such activities are related to a workers' compensation plan, in the adoption order also.

Commenters express concerns regarding proposed §19.1706(a) and §19.2006(a) related to qualification requirements. Insurance Code §4201.252 is very specific regarding the qualifications of personnel. Specifically, Insurance Code §4201.252(c) makes clear that personnel who perform clerical or administrative tasks are not required to be licensed, clinical staff. The commenters express confusion over the reference in the second sentence to an administrative license and are concerned TDI would require administrative staff to be licensed in some capacity. The commenters believe §19.1706(a) and §19.2006(a) should more closely track the statutory requirements in Insurance Code §4201.252, including the inapplicability of licensure requirement when performing clerical or administrative functions.

A commenter expresses concern over §19.2006(a). The commenter asserts that the proposed rule is too broad in defining the scope of utilization review and goes beyond the requirements of the statute. In addition, the language, if read literally, could be interpreted to apply to even routine administrative tasks that are part of utilization review, such as requesting medical records.

The commenter asserts that §19.2006(a) should be modified to include an exception that persons conducting strictly administrative functions do not need to be licensed. The commenter recommends adding a phrase after "physicians, doctors, and other health care providers employed by or under contract with a URA to perform utilization review" to state "and who render adverse determinations."

Agency Response: TDI agrees to make changes to §19.1706(a) and §19.2006(a) to clarify that it does not require qualifications for clerical or administrative staff and to more closely track the statutory requirements in Insurance Code §4201.252. TDI added paragraph (2) that states, "Personnel who perform clerical or administrative tasks are not required to have the qualifications prescribed by this subsection." TDI also clarifies that this information may also be found in the applicability section of both Subchapters R and U in §19.1702(a)(2) and §19.2002(a)(2), respectively.

Comment: A commenter appreciates and supports §19.2006(b). However, the commenter recommends that the words "in itself" be deleted as they could result in confusion about the intent of this provision of the rule.

A commenter asserts that §19.2006(b) should be stricken as unnecessary, redundant, and potentially confusing. The subsection attempts to set forth potential "disqualifying associations," but §19.2003(b)(8) of the definitions section already contains a full provision regarding what constitutes a disqualifying association. A commenter asserts that proposed §19.2006(b) should be withdrawn.

A commenter requested clarification that this provision would not prohibit a URA from providing services to its affiliate HMO or affiliate insurer. A commenter notes that while §19.1706(b) is laudable, it is administratively difficult and may reduce the pool of potential reviewers.

A commenter notes that certain subjective bases contained in the rule, for example, disqualifying associations, do not provide adequate guidance to participants in determining appropriate conduct.

A commenter disagrees with the language in §19.2006(b) that addresses disqualifying associations for the doctor performing the appeal of the initial URA determination. The commenter believes that the fact that the reviewing doctor is employed by or under contract with the same URA that issued the initial adverse determination should be a disqualifying association. It is important for the efficacy of the system that the review of the initial determination be conducted by a person whose objectivity cannot be reasonably questioned. That goal would be significantly undermined if the review of the adverse determination can be made by someone who is employed by or under contract with the same URA that issued the initial adverse determination. The commenter also suggests adding §19.2006(b)(3) stating "any designated doctor or IRO doctor in the case." The commenter notes that giving this more expansive definition of disqualifying association will further the objective of avoiding impropriety or the appearance of impropriety.

Agency Response: TDI declines to make the suggested changes and clarifies that being employed by or contracted with the same URA as the physician, doctor, or other health care provider who issued the initial adverse determination does not in itself constitute a disqualifying association; however, another disqualifying association may apply.

These provisions are necessary to prohibit potential conflicts of interest that could undermine the appeals process for adverse determinations. The purpose of adopted §19.1706(b) is to prohibit the physician who reviews the appeal from being improperly influenced based on a relationship that he or she has with the physician, doctor, or other health care provider who issued the initial adverse determination, or the enrollee who is requesting the appeal. This concept is an extension of the prohibition that an appeal must include a review by a health care provider who has not previously reviewed the case under Insurance Code §4201.357.

In response to the comment that TDI give a more expansive definition of disqualifying association, TDI declines to make the suggested change because such an interpretation of a disqualifying association is overly narrow. If the reviewing physician or doctor has already been involved in the case, then the individual is already disqualified under the proposed requirements. Existing rules do not even define "disqualifying association," so proposed §19.2006(b), along with the definition under proposed §19.2003(8), adds important safeguards without being overly burdensome or restrictive. TDI disagrees that objectivity will be compromised solely on the basis that the individual is employed by or under contract with the same URA as the physician, doctor, other health care provider who issued the initial adverse determination.

Comment: A commenter is perplexed regarding the rationale for the new requirement to file names and licensing information of utilization review personnel in §19.1706(c). The commenter knows of no other licensed entity that is required by TDI to identify personnel by name other than required officer and director filings. While this task is not impossible, the commenter indicates that it is very burdensome, particularly in regard to contract physician reviewers. The commenter indicated that it had 100 nurses dedicated to utilization reviews in Texas and, nationwide, the entity employed over 1,400 nurses that might provide services and would possibly need to be identified in the application process. Further, it is the commenter's understanding that many health plans contract with hundreds of physician reviewers, many associated with academic institutions. The commenter believes it will be difficult to ensure that accurate information is on file with TDI due to the volume of personnel employed by or under contract with a URA, especially those affiliated with large national health plans. The commenter prefers deletion of this requirement.

The commenter requests clarification of the "number" reporting requirement and suggests limiting the requirement to personnel employed by or under contract with the URA on a full-time basis to avoid having to identify all contracted peer reviewers that may provide services only on a very limited or case-by-case basis.

Agency Response: TDI declines to make the suggested deletion of the entire section. This information is important because it allows TDI to monitor the credentials of staff performing utilization review. To avoid unnecessary administrative burden, TDI clarifies that URAs are not required to provide information on any administrative staff not conducting utilization review. These sections clarify that the URA is only required to notify TDI when filing its original or renewal applications.

Additionally, the URA application Form LHL005 requires the URA to notify TDI of a material change. For example, if one nurse stops working for the URA, the change might not be material. However, if the URA loses all of its nurses, notification would be required.

TDI deleted "number" from the requirements, because the license number reporting requirement is already included in the section.

Comment: One commenter expresses support for §19.2006(e), as it requires a Texas licensed physician who is without restriction on his or her license to be utilized.

Agency Response: TDI appreciates the supportive comment.

§19.1707 and §19.2007. URA Contact with and Receipt of Information from Health Care Providers.

Comment: A commenter expresses concern over proposed §19.2007(a). The commenter requests that the commissioner of insurance and TDI staff take notice of the fact that the issue of the need for medical records to be submitted with medical bills has been dealt with in the not too distant past by TDI-DWC when there were discussions about limiting the amount of medical records insurance carriers could receive with medical bills. The commenter asserts that, after much discussion among system stakeholders, health care providers and insurance carriers rejected limiting the amount of medical records that health care providers submit with medical records. The role of medical documentation is one of great significance in the Texas workers' compensation system. The receipt and review of medical records drives forward the evolution of a workers' compensation claim from one stage to another, and directly influences the efficiency and appropriateness of claims handling and stakeholder decision making at each level.

The commenter further explains that the Texas workers' compensation system mandates that the injured worker receive health care reasonably required to treat the compensable injury based on the application of evidence-based medicine. A utilization review agent cannot form a reasoned and appropriate opinion on the medical necessity or appropriateness of health care services without reviewing medical records. Further, the URA cannot appropriately apply the evidence-based treatment guidelines adopted by the DWC or adopted by the health care network without reviewing the medical evidence found in the records. The commenter believes that it is imperative that TDI not attempt to limit the amount of medical records that are made available to insurance carriers, as such a public policy will have a significant negative impact on claims handling in the Texas workers' compensation system.

The commenter suggests TDI delete the phrase, "If a URA must reimburse health care providers for providing" and replace the phrase with "If a URA requests required," in §19.2007(a). The commenter suggests that TDI require reimbursements to be made by the insurance carrier and suggests addition of the phrase, "The provider of record must obtain and provide all relevant and updated medical records to the URA so that a complete review of the health care may be conducted by the URA."

A commenter states that §19.1707(a) rewrites the current 19.1708(b) related to reimbursement for medical records and removes the language related to "modification by contract." The current language is preferable because provider contracts generally either obligate the provider to provide records at no cost or contain a negotiated cost. The revision of this provision appears to consider only two options, the provider must provide at no cost or at a cost limited to the current TDI-DWC rule cap on medical records. The commenter requests that the rule be revised to address negotiated rates for medical records.

A commenter notes that 28 TAC §134.600 requires the medical provider to submit any and all information necessary to support and substantiate the medical necessity of the requested services. Section 19.2007 appears to be in conflict with 28 TAC §134.600. The commenter requests that §19.2007(a) be amended to exclude any information that is required by 28 TAC §134.600 to be included with the information request.

Agency Response: TDI declines to make the suggested changes. TDI clarifies that there is a difference between all relevant records and all records. TDI is not asserting that a determination of whether medical care is appropriate and necessary can be made without reviewing any medical records. The necessary or pertinent sections of the medical records are the relevant records.

In response to the comment that §19.2007 improperly limits the amount of medical records and is in conflict with §134.600, TDI clarifies that the intent of the rule is to prevent the URA from requiring unlimited amounts of medical records from the requestor, some of which may not inform the decision of whether care is medically necessary or appropriate. This rule will help control costs in harmony with the legislative intent.

TDI clarifies that adopted §19.1707(a) only requires a URA to reimburse a health care provider for the reasonable costs of providing medical information in writing if required under Insurance Code §4201.207. If the reimbursement is precluded or modified by contract, then the URA is not required to reimburse the health care provider under Insurance Code §4201.207, and adopted §19.1707(a) will not apply. The language related to "modified by contract" is retained in Insurance Code §4201.207.

Comment: A commenter asserts that §19.2007(b) exceeds the statutory rulemaking authority of TDI. The commenter asserts that this is another incident in which TDI drafted rules as if the Insurance Code prevailed over the Labor Code in violation of Insurance Code §4201.054(c). The statutory basis for this proposed rule provision appears to be Labor Code §408.0046. That statute expressly provides that the rules adopted under §408.0046 ". . . must require an entity requesting a peer review to obtain and provide to the doctor performing peer review services all relevant and updated medical records." A health care provider that is requesting preauthorization or concurrent review of healthcare services is an entity requesting a URA peer review doctor to review and approve requested health care services. In those instances, the statutory duty is on the health care provider to obtain and provide all relevant and updated medical records to the URA. When the carrier is requesting the URA to perform retrospective review of medical services that have already been provided, then the carrier is the entity requesting a peer review and must obtain and provide all relevant and updated medical records. The statute does not impose a duty on the URA to request all relevant and updated medical records. The commenter recommends requiring the provider of record to obtain and provide all relevant and updated medical records in order to complete the review. The commenter suggests adding the sentence, "When conducting retrospective utilization review, the carrier must obtain and provide all relevant and updated medical records to complete the review."

A commenter asserts that the problems in proposed §19.2007(b) are accentuated in proposed §19.2007(b)(2). The commenter asserts that limitations on requesting necessary and pertinent medical records conflicts with proposed §19.2007(b) and Labor Code §408.0046. The commenter asserts that TDI is exceeding its rulemaking authority by eliminating the duty of the entity to obtain and provide all relevant and updated medical records and imposing a duty on the URA to request the records, and restricting the right to receive and review the statutorily mandated records. The commenter asserts that TDI is prohibited from turning the requirements of the Labor Code upside down in favor of the Insurance Code as legislatively mandated in Insurance Code §4201.054(c).

A commenter asserts that a mandatory requirement in §19.1707(b) and §19.2007(b) will add cost and delay. The URA would certainly argue that even if all "relevant" records were not needed to complete the review, the rule mandates that they be demanded and submitted. Further, the mandate for all records may conflict with the requirement of paragraph (2) which prohibits routinely requesting copies of medical records. The proposed language should be changed to provide authority to require records but not mandate every record if not needed to complete the review. The commenter asserts that the language should be amended to read, "When conducting routine utilization review, the URA may request only relevant and updated medical records in order to complete the review."

A commenter states that a previous informal draft to §19.2007(b) prevented a mandatory requirement for such things as CPT codes. The commenter notes that the requirement would have required, for example, a surgeon to be clairvoyant as he or she would not know the exact coding of a procedure until after a particular procedure was performed. The commenter asserts that this type of regulation should be included in the current proposal to prevent abuse.

The commenter suggests adding the following language as a paragraph to §19.2007(b) "URAs must not routinely require hospitals and physicians to supply numerically codified diagnoses or procedures. URAs may ask for such coding, when it is known and its inclusion in the data collected increases the effectiveness of the communication." The commenter suggests adding, "Additional information may be requested by the URA or voluntarily submitted by the provider of record when there is significant lack of agreement between the URA and provider of record regarding the medical necessity and appropriateness of health care during the review of appeal process." "Significant lack of agreement" means that the URA: (1) tentatively determined that a health care service cannot be approved; (2) referred the case to a physician, doctor, or other health care provider for review; and (3) discussed or attempted to discuss obtaining further information with the provider of record." The commenter asserts that the suggested language would be of great value to patients and their health care providers. It would enable physicians and the patients they serve to provide additional information to resolve an impasse or perceived impasse concerning medical necessity. The voluntary nature allows a physician or patient to proactively be an advocate.

A commenter objects to the requirement to obtain all medical records as overly burdensome, particularly for providers. The commenter also believes it conflicts with the recommendation of the Utilization Review Advisory Committee. In addition, the commenter states that it appears to contradict paragraph (2), which prohibits routinely collecting copies of all medical records. Finally, as raised at the stakeholder meeting, the language regarding "all relevant medical records" is based on Labor Code §408.0046. This Labor Code provision also contains an obligation on the requesting provider to provide all relevant and updated medical records. There is no corresponding provision in the Insurance Code, nor is there a statutory obligation on the

provider. The commenter prefers the language contained in the current rules.

A commenter recommends amending §19.2007(b) by moving the phrase "relevant and updated" to the end of the sentence. The commenter asserts that the proposed change clarifies that the URA must request relevant medical records to conduct the utilization review.

A commenter expresses concern that §19.2007(b) exceeds the statutory rulemaking authority of TDI. The statutory basis for this proposed rule provision appears to be Labor Code §408.0046. However, that statute limits appropriate rulemaking authority to the commissioner of the Division of Workers' Compensation and does not provide rulemaking authority to the commissioner of the Texas Department of Insurance.

A commenter expresses concern over §19.2007(b)(2). The commenter does not understand how a URA can make an informed decision regarding medical treatment without the injured employee's medical records. The provision goes on to say that records should be required only when difficulty develops in determining whether the health care is medically necessary or appropriate "or experimental or investigational in nature." The commenter does not understand the reference to treatment being experimental or investigational in nature since that status is not a basis for denying medical treatment in workers' compensation. Labor Code §413.014(c)(6) and 28 TAC §134.600(p)(6) identify investigational or experimental services or devices as health care requiring preauthorization. By identifying such treatment as requiring preauthorization in workers' compensation, the statute and rule clearly envision that the experimental or investigational nature of the treatment is not a basis in and of itself for denying the treatment. Accordingly, the commenter believes further explanation is required as to the purpose and effect of having a URA make a determination that the proposed treatment is experimental or investigational.

A commenter asserts that §19.2007(b)(2) is inconsistent with the proposed §19.2007(b) mandate that a URA "must request all relevant and updated medical records." The section is also confusing, ambiguous, and fails to set forth a real standard to guide actions. A URA needs all relevant medical information to make an informed determination regarding whether the health care service is medically necessary and appropriate under the workers' compensation law. This proposed rule is inconsistent with the goal of providing effective utilization review. To suggest that relevant medical records can only be requested "when a difficulty develops in determining whether the health care is medically necessary or appropriate or experimental or investigational in nature" reverses the entire meaning of utilization review as set forth by the Texas Workers' Compensation Act. A URA may only perform effective, meaningful utilization review after the provider has supplied all relevant medical records. It is simply impossible to determine whether "a difficulty" has developed until after the medical provider has supplied the URA with all relevant medical records. The commenter asserts that proposed section 19.2007(b)(2) should be withdrawn.

A commenter asserts that §19.2007(b)(2) and (c) is problematic on several levels and should be removed. The first sentence seems to conflict with the proposed introductory paragraph of subsection (b) that expressly requires the URA to request all relevant and updated medical records to complete a utilization review. The second sentence suggests that utilization review can be completed without a review of medical records, which conflicts with the proposed introductory paragraph to subsection (b). Section 19.2007(b)(2) appears to conflict with the introductory paragraph to subsection (b) and is impractical. It is unknown how the URA will know what sections of records to ask for, because the URA has not seen them.

Because it is the duty of the health care provider to substantiate the medical necessity and appropriateness of medical services submitted to the URA for review, the commenter seeks clarification on any authority to require URAs to share medical records already in their possession but related to separately-submitted utilization review requests on separate issues, injuries, or body parts. Additionally, clarification is sought that no carrier or URA liability or waiver will attach based on medical records on an injured worker already in the possession of a URA, but not submitted by the health care provider with the utilization review request that may or could otherwise be found to substantiate the medical necessity and appropriateness of the health care provider services. Liability or waiver would effectively shift the burden of production onto the reviewer and not the health care provider. Utilization review is a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services. A URA cannot form a reasoned expert opinion on the medical necessity or appropriateness of health care services without reviewing medical records, therefore health care providers should provide the entire record rather than redacting sections before submitting "necessary or pertinent" sections for review. The Texas workers' compensation system mandates that the injured worker receive health care reasonably required to treat the compensable injury based on the application of evidence-based medicine. The URA cannot apply the evidence-based treatment guidelines adopted by TDI-DWC or adopted by the health care network without reviewing the medical evidence found in the records. To encourage utilization review based on no records or partial records puts the injured employee's health and livelihood at substantial risk.

Agency Response: TDI declines to make the suggested changes. In accord with Labor Code §§402.00111, 402.00116, and 402.00128 and Insurance Code §4201.054, the commissioner of workers' compensation has delegated to the commissioner of insurance the authority to adopt rules regulating utilization review of a health care service provided to a person eligible for workers' compensation medical benefits under Labor Code Title 5, in Order No. DWC-11-0063, dated June 21, 2011.

TDI relies on rulemaking authority under Insurance Code §4201.003 and §36.001 in adopting these rules, not on Labor Code §408.0046.

As previously discussed, in terms of prospective and concurrent utilization review, existing Chapter 10 rules (for network care) and Chapter 134 rules (for non-network care) clarify that a health care provider submitting a request for health care services must include information to substantiate the medical necessity of the services requested.

In terms of retrospective utilization review, existing Chapter 133 rules, which apply to both network and non-network care, clarify both when medical information must be submitted and the types of information that must be submitted along with a medical bill for health care services that have already been rendered.

Existing §19.2008(c) requires the URA to require information necessary to complete the utilization review and provides that such information should be obtained from the appropriate source. Section 19.2008(c), like §19.1708(c), is designed to

allow the URA to seek the information necessary for the review on a case-by-case basis without routinely requesting an entire medical record for an injured employee. Such a balance in the amount of information requested will result in a more efficient review because of both the relevance of the provided documents and the reduced cost. Even though the requesting party is required to submit information to support the request, the URA should request missing information, if known, as a matter of due diligence. Additionally, a description of any documentation or evidence that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision, should be discussed in the peer-to-peer discussion, as required under existing §19.2010.

TDI clarifies that this subsection is not a new concept as suggested by the commenter, except that the adopted rules now match the payment responsibility for medical information requested by the URA in Subchapter U with the payment responsibility described in §19.1707 of Subchapter R. Additionally, §19.2007(a) as published updates outdated rule references relating to the reimbursement of medical documentation by eliminating references to the former Texas Workers' Compensation Commission and including 28 TAC §134.120 (relating to Reimbursement for Medical Documentation). Under existing rules, the URA was already required to request the information necessary to complete the review and could only request information relevant to the review.

TDI disagrees that §19.2007(b) limits the number of medical records that are made available to insurance carriers. An insurance carrier may already have been provided written medical information that is now being requested by the URA. In such a case, the insurance carrier is obligated to supply the URA with whatever medical information it may already have received from the health care provider to avoid unnecessary requests for information from the health care provider. However, if the insurance carrier is not able to provide this information to the URA or does not have this information and the URA has determined that the information is necessary to conduct utilization review, then the URA, with whatever financial arrangements it has with the insurance carrier, is expected to reimburse the health care provider for the requested written medical information. In response to comments, TDI modified §19.2007(b) by deleting "A health care provider must" and inserting "Nothing in this subsection removes the health care provider's requirement to," to clarify that the health care provider must still provide information to substantiate the medical necessity of health care requested under 28 TAC Chapter 134.

TDI declines to revise §19.1707(b). The URA should determine the medical records that are relevant for the review. Section 19.1707 is designed to allow the URA to seek the information necessary for the review on a case-by-case basis without routinely requesting an entire medical record. The intent is to require the URA to identify the records it needs. Section 19.1707(b) does not require an overly broad request that would result in the transmission of unnecessary information. Existing text under §19.1708(c) states, "These items shall only be requested when relevant to the utilization review in question and be requested as appropriate from the beneficiary, plan sponsor, health care provider, or health care facility." Thus, existing regulations already require that requested items be relevant to the utilization review.

In response to comments that the rules should prevent a mandatory requirement for CPT codes, TDI declines to make the suggested change because the prohibition is outside the scope of the URA rules.

TDI is not asserting that a determination of whether medical care is appropriate and necessary can be made without reviewing any medical records. This provision is intended to clarify that a URA should not routinely request a copy of all of the injured employee's medical records on injured employees reviewed. Additional language in §19.2007(b)(1) states that the URA must request all relevant and updated information and medical records to complete the review. All of the provisions of §19.2007 should be read together to fully understand the circumstances in which medical records may be requested by the URA. These provisions read together are intended to clarify that a URA should request additional medical records that are pertinent to the health care services that the URA is actually reviewing. However, the URA should not request a complete copy of all medical records for every injured employee if those records are not pertinent to the services being reviewed.

Additionally, TDI clarifies that under Labor Code §408.021, an injured employee under both network and non-network coverage is entitled to all medically necessary health care services, including experimental and investigational health care services, so the URA has the ability to ask for those records if needed.

The definition of adverse determination in adopted §19.2003(b)(1) clarifies that, for the purposes of Subchapter U, an adverse determination does not include a determination that health care services are experimental or investigational. However, TDI further clarifies that the determination of whether a service is experimental or investigational must be made by a URA, and not a claims adjuster, because the URA possesses the medical expertise needed to make that determination. To make this determination, the URA may need to request additional medical records as necessary on a case-by-case basis.

TDI asserts that no conflict with the last sentence and the introductory paragraph to §19.2007(b) exists. The necessary or pertinent sections are the relevant records.

Comment: A commenter seeks clarification on the perceived conflict between provisions of §19.2007(c) that require a URA to share among its divisions all clinical and demographic information on individual injured employees, and the provisions of §19.2013(b)(1)(A) that address written procedures on confidentiality of information received and exchange of that information.

A commenter asserts that §19.2007(c) is inconsistent with other requirements that the medical information be kept confidential and that only those records relevant to the utilization review be reviewed. The commenter asserts that proposed §19.2007(c) should be stricken.

Agency Response: TDI clarifies that URAs must comply with Insurance Code Chapter 4201, Subchapter L (regarding confidentiality of information: access to other information and applicable laws). Adopted §19.2007(c) mirrors the requirements in existing §19.2008(e). The provision is necessary to avoid duplicate requests for information from injured employees, physicians, doctors, and other health care providers, and is not meant to supersede or conflict with the confidentiality requirements under the law.

Comment: A commenter asserts that proposed §19.2007(d) is arbitrary and unreasonable. Where an injured claimant puts his emotional condition in dispute and is requesting indemnity and

medical benefits for such condition and where the therapist is requesting payment for such services, it is absolutely essential that the URA be able to review all records for the treatment for such emotional condition. These records include the process or progress notes relating to the treatment. Utilization review is an extremely critical process to make sure the injured worker is getting the proper treatment so that the worker's condition can improve. It is also critical to make sure that the health care provider is dispensing service in a productive an effective manner. To put a blanket prohibition on the review of the mental health provider's process and progress notes would render effective utilization review of mental health care impractical. A full and complete review of such health care is essential for effective utilization review. The commenter asserts that proposed §19.2007(d) should be withdrawn.

Agency Response: TDI declines to make the suggested deletion. TDI clarifies that §19.2007(d) implements Insurance Code §4201.303, which prohibits a URA from requiring, as a condition of treatment approval or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes.

§19.1708 and §19.2008. On-Site Review by a URA.

Comment: A commenter asserts that several health care facilities are requiring URA on-site review staff, which includes case managers, to not only register with the health care facility but do so with an outside credentialing vendor who charges a registration fee. The level of the registration fees per URA staff member has purportedly been significant. This practice is inappropriate and could interfere with the on-site audit process and prevent access to health care facilities. To prevent this inappropriate practice, the commenter requests that TDI amend the rule by adding a subsection (b) that states, "The health care facility or an agent of the health care facility shall not charge an insurance carrier or the URA or the URA's staff a registration or other fee as a condition to enter the health care facility to conduct onsite audit or to visit an injured employee."

Agency Response: Insurance Code §4201.207 already provides limits on a health care provider's charges for medical information, unless precluded or modified by contract with the URA, and Insurance Code §4201.202 provides that these sections cannot be construed to otherwise limit or deny contact with a patient for purposes of conducting utilization review, unless otherwise specifically prohibited by law.

If the commenter has concerns about on-site reviews at health care facilities, the commenter can file a complaint and TDI will consider whether the health care provider or health care facility has violated the Insurance Code, Labor Code, or TDI-DWC rules regarding charges for on-site review.

Comment: A commenter requests that TDI clarify that the requirement in §19.1708(b) for requesting medical records when conducting utilization review applies only to those medical records that are relevant to the service under review, particularly given the expansive definition of medical record.

Agency Response: TDI clarifies that this provision is found in §19.1707(b). Adopted §19.1707(b) and §19.2007(b) require the URA conducting utilization review to request "all relevant and updated information and medical records" to complete the review. This ensures that the URA uses the most recent and complete information possible to review the treatment of the enrollee or injured employee, respectively. Although treatment may vary on a case-by-case basis, TDI determined that this requirement will enable the most effective review. Existing text under §19.1708(c) stated, "These items shall only be requested when relevant to the utilization review in question and be requested as appropriate from the beneficiary, plan sponsor, health care provider, or health care facility." Thus, existing regulations already required that requested items be relevant to the utilization review.

§19.1709 and §19.2009. Notice of Determinations Made in Utilization Review.

Comment: Regarding the data elements and format requirements noted in proposed §19.2009, the commenter respectfully requests that TDI-DWC be mindful of the time it will take to comply with these changes in the various systems and allow for such changes that are not currently in place. It is the commenter's opinion that it could take approximately 12 months to be able to change current systems and be able to fully comply.

Agency Response: TDI declines to make the suggested change to the effective date of the adopted rules. TDI, as explained in the reasoned justification, has determined that giving stakeholders 90 days to comply from the date the adoption order is filed with the Secretary of State is sufficient.

Comment: A commenter expresses concern over §19.2009. The commenter states that the rule is overreaching and would create unintended confusion in the system. The commenter states that it appears the rules require the commenter to, before issuing a peer review report, consult with a treating provider and then, once the report is issued, provide notice of the peer review's opinion, including a description of TDI's complaint procedure, a description of the commenter's complaint system, and notice of the independent review process. Such actions would appear to be premature and initiate confusion in the system. In some cases, the commenter may address care that has not been proposed or has already been authorized, performed, and reimbursed. For example, the commenter may be asked to address what possible surgery may be appropriate for a specific injury, even though surgery has not been discussed or proposed, or whether a surgery that has either been already authorized or performed and reimbursed was necessary and appropriate. In these cases, the commenter's peer review would have no impact on the authorization of such care, as either preauthorization has not been requested (which would go through the carrier's own URA) or the care has already been authorized, rendered, or paid (actions that would typically be handled through the carrier's own URA).

The commenter states that requiring contact with a treating physician and issuing the required notices would be premature because, the commenter has no authority to deny authorization or reimbursement on behalf of a carrier. Under Labor Code §413.031, a party is only entitled to seek medical dispute resolution after there has been a denial of authorization or payment for care, neither of which the commenter is authorized to perform on behalf of its clients. To require the commenter and similar entities to perform the required consultations and issue the required notices would, at the very least, result in the provision of unnecessary notices to system participants and encourage premature complaints or appeals, as there has been no denial of authorization or reimbursement for care. Indeed, carriers, utilizing their own URA's, often authorize or reimburse care that the commenter's peer review physician indicated may not be necessary or appropriate. This happens for a number of reasons, including the progression of an injury or treatment that has occurred between the time of peer review and the date authorization is requested or treatment is sought.

Agency Response: TDI clarifies that the requirements contained in adopted Subchapter U do not apply to peer reviews performed for issues other than the review of medical necessity or appropriateness of health care, such as compensability or an injured employee's ability to return to work. This provision delineates requirements for peer reviews performed for the evaluation of medical necessity or appropriateness of health care versus peer reviews performed for other issues, such as extent of injury issues.

Comment: A commenter questions the need to identify the specialty of the physician reviewer in §19.1709(b). While the URA would have this information available, adding this requirement to the standardized notices will only add to the administrative costs of providing utilization review services.

The commenter requests TDI clarify that leaving a message, with a live person or a machine, qualifies as "direct telephone contact to the individual making the request" as required under §19.1709(c) because it is very difficult to get physicians on the phone. The plans will offer a peer-to-peer if the physician calls back.

Although the commenter recognizes the requirement for a "letter" for adverse determinations, the utilization review statutes do not require a written notice of a favorable determination, which would create an additional administrative burden, especially for plans that only have CHIP and Medicaid lines of business.

The commenter suggests that §19.1709(d)(3) be clarified by including all of the statutorily required timeframes.

Agency Response: TDI asserts that although these rules potentially increase administrative costs, they are nevertheless necessary to implement HB 4290, make other changes necessary for clarity and effective implementation of Insurance Code Chapter 4201, and improve the regulatory framework for URAs. TDI has determined that the benefit of such information outweighs the fact that providing it may be burdensome, expand the length of the letters, or add to cost. This information may assist the provider of record in assessing whether the enrollee will benefit from requesting a physician or doctor of a particular specialty, other than the specialty of the physician or doctor that made the adverse determination, if an appeal to the adverse determination is filed.

TDI clarifies that leaving a message is not considered direct telephone contact between the health benefit plan issuer to a representative of the issuer in proposed §19.1709(c). Section 19.1709(c) is consistent with the Insurance Code §1352.006. Section 1352.006 provides that in that section, "utilization review" has the meaning assigned by §4201.002. Notwithstanding Chapter 4201 or any other law relating to the determination of medical necessity under the Insurance Code, §1352.006 requires a health benefit plan to respond to a person requesting utilization review or appealing for an extension of coverage based on an allegation of medical necessity not later than three business days after the date on which the person makes the request or submits the appeal. Section 1352.006 further requires the person to make the request or submit the appeal in the manner prescribed by the terms of the plan's health insurance policy or agreement, contract, evidence of coverage, or similar coverage document. To comply with these requirements, §1352.006 requires the health benefit plan issuer to respond through a direct telephone contact made by a representative of the issuer.

Section 19.1709(a) addresses requirements for both favorable and adverse determination notices and tracks the requirements in existing §19.1710(a). TDI declines to make the suggested change because §19.1709(a) implements a statutory provision. Insurance Code §4201.301 requires the URA to provide notice of a determination made in utilization review, not only adverse determinations.

TDI declines to make the suggested change to §19.1709(d)(3) because the required timeframes for notice of an adverse determination are provided in Insurance Code §4201.304, and repetition of the provisions would be redundant.

Comment: A commenter requests that TDI add the sentence "This section does not apply to a peer review by a URA that is not used as a basis to deny authorization or reimbursement for health care" to the end of §19.1709(a).

Agency Response: TDI declines to make the suggested change. In terms of the applicability of utilization review requirements to peer review functions in the Texas workers' compensation system, TDI reminds stakeholders that §180.22(g), which was first adopted in 2006 and later updated in 2011 states, in part, that "a peer reviewer who performs prospective, concurrent, or retrospective review of the medical necessity or reasonableness of health care services (utilization review) is subject to the applicable provisions of the Labor Code; Insurance Code, Chapters 1305 and 4201; and TDI and TDI-DWC rules." This rule further states that a peer reviewer who performs utilization review must be certified or registered as a URA by TDI or be employed by or under contract with a certified or registered URA. The language in §19.2002(b)(1) reminds stakeholders of the requirements that already apply to peer reviewers under TDI-DWC's Chapter 180 rules.

Comment: A commenter objects to the references to other codes and rules and the cross-referencing to other sections of this title in §19.2009(a)(2), (3), and (4). The use of these references and cross-references make it impossible to understand what these sections mean without consulting other material and thus makes this material difficult to follow, particularly by lay people.

The commenter recommends that §19.2009(a)(2) and (3) be revised to specifically identify the parties to whom notice of the determination of prospective, concurrent, and retrospective utilization review must be given in both network and non-network claims rather than referencing other provisions in the administrative code.

Agency Response: TDI declines to delete the references to other codes and rules because URAs are required to comply with the cited rules and statutes, and inclusion of the entire text from other rules and statutes would be repetitive. TDI has determined that the rules are more streamlined and easier to understand by including cross-references, and also URAs are on notice that they are subject to the requirements in other rules and statutes.

Comment: A commenter asserts that §19.2009(a)(3) does not include a reference to the notice timeframe established by DWC in 28 TAC §133.250 for reconsideration of payment of medical bills.

Agency Response: TDI clarifies that the reference to 28 TAC §133.250 already appeared in the proposal under §19.2009(a)(3), so no addition is required.

Comment: A commenter requests clarification in §19.2009(a)(3)(A) and (B). The commenter questions whether the notice of appeal and peer-to-peer discussion for retrospective utilization review only need to take place at the time of a medical bill adverse determination

Agency Response: TDI clarifies that the provider of record is entitled to a reasonable opportunity, as defined in §19.1703(b)(26) and §19.2003(28), to speak to a physician or doctor before an adverse determination is issued by a URA who questions the necessity or appropriateness, or the experimental or investigational nature, of a health care service.

Comment: A commenter asserts that the requirements in 45 C.F.R. §162.1102 have to do with medical bill review, which is not the same as utilization review. In addition, these federal rules and electronic billing formats only say this can be assigned by the carrier to identify the preauthorization. It can be alphanumeric, one to 30 characters. The commenter is not sure how TDI believes this requirement will prevent different numbering systems. Utilization review is not subject to the federal regulation as a preauthorization determination and is not considered a billing form.

Agency Response: TDI clarifies that the preauthorization number assigned by the insurer's URA is the preauthorization number that health care providers must include in medical bills submitted using the implementation specifications adopted by federal and state regulations. While the electronic transmission of data may or may not occur during the utilization review process, it does occur when a health care provider submits a medical bill for payment.

Title 45 C.F.R. §160.1102 applies the federally adopted standards, requirements, and implementation specifications to health plans, health care clearinghouses, and health care providers "who transmit any health information in electronic form in connection with a transaction covered by this subchapter." While these federal requirements do not apply to all insurers or insurance carriers, the definition of health care providers is broad and includes any health care provider that electronically submits a medical bill.

Texas regulations already require the use of these billing standards and requirements for health plans and workers' compensation insurance carriers, which are the lines of insurance applicable to the utilization review rules. Insurance Code §1213.002 establishes that the insurer of a health benefit plan may contractually require health care providers and facilities to electronically submit medical bills and, if the contract provides for this type of submission, 28 TAC §21.3701 requires the use of the federal standards for electronic submissions. Labor Code §408.0251 and 28 TAC §133.501 require the electronic submission of medical bills for services provided under the Texas Workers' Compensation Act using these same standards and requirements.

A URA working on behalf of an insurer or insurance carrier that assigns a preauthorization number that is inconsistent with these electronic standards unilaterally imposes an obstacle to the accomplishment of the full purposes and objectives of administrative simplification, at both the federal and state level. For example, a URA that assigns an alphanumeric preauthorization number for a prescription medication could create a situation in which a retail pharmacy's electronic medical bill is rejected by the insurer's or insurance carrier's clearinghouse (the current federal and state mandated transaction sets requires a numeric format). It would be incongruous for TDI to require a health care provider to submit an electronic medical bill while permitting a situation where the insurer's contracted agent can assign a number that would delay prompt payment or penalize the health care provider for submitting the medical bill electronically.

Accordingly, compliance with these standards and implementation specifications already exists for health plans and workers' compensation insurance carriers, including their agents or business associates. Requiring the use of the required billing format in the assignment of these numbers by the insurer's URA removes a potential insurer-imposed barrier to the electronic submission of medical bills by health care providers.

TDI clarifies that the defined format for the preauthorization number is the format required for the applicable data element in the transaction standards adopted by the Federal Department of Health and Human Services (HHS) related to the submission of electronic health claims (billing requirements). Requiring the same format contained in these standards ensures that the health care provider can submit an electronic health care claim or bill, and that the health care claim or bill will be accepted by the health plan or insurer, as opposed to being rejected because the preauthorization number assigned by the URA did not meet these format requirements.

The Code of Federal Regulations may be accessed on the Internet at: www.gpoaccess.gov/cfr/index.html.

Comment: A commenter requests a delay in the effective date for §19.2009(a)(4) regarding the preauthorization numbers, claiming it will require a minimum of four months to program the utilization review system to comply with proposed §19.2009(a)(4).

Agency Response: TDI declines to extend the effective date. Texas regulations already require the use of these billing standards and requirements for health plans and workers' compensation insurance carriers, which are the lines of insurance applicable to the utilization review rules. TDI received input from one industry group that a 90-day period would be sufficient, and TDI agrees that 90 days is reasonable.

Comment: A commenter recommends that §19.2009(b) be changed to require the URA to include a list of the documents reviewed in making the adverse determination. Proposed §19.2010 requires the URA to provide the medical provider a reasonable opportunity to discuss "a description of documentation or evidence, if any, that can be submitted by the provider of record, that upon reconsideration or appeal, might lead to a different utilization review decision." If that information were supplemented with the list of documentation reviewed, it would permit the provider to determine if such evidence already exists and simply was not provided to the URA or whether additional evidence must be obtained before requesting reconsideration. The determination of how to supplement the initial request has to be made quickly to ensure compliance with the deadlines for requesting reconsideration. The commenter asserts that inclusion of a requirement that the URA list the documentation reviewed would provide greater efficiency in the process.

A commenter urges TDI to include in §19.1709(b) a requirement that all notices of adverse determination include a description of documentation or evidence, if any, that can be submitted that might lead to a different utilization review decision on appeal, as was required in §19.1715(b)(2)(D) of the URA rules proposed in 2011. This information could be critical to a consumer obtaining needed health care. Providing this information is a key step in setting up transparent and understandable processes for utilization review and appeals that consumers can successfully navigate. As was expressed in TDI's preamble to its 2011 proposed rule, this information is "necessary to provide important consumer information to the enrollee and the provider of record

in the event that the adverse determination is appealed." In some cases, all that is needed to prove medical necessity in an appeal is missing medical imaging or diagnostic test results.

Ensuring that URAs inform consumers of what medical record is missing or what evidence could reverse the decision will improve a patient's access to medically necessary and appropriate care. Sharing this information with consumers and providers will promote the delivery of quality care in a cost-effective manner and foster greater coordination and cooperation between providers and URAs - two key goals of these rules. Consumers will benefit from having this information in two ways. If they choose to appeal, it will help them be more successful in getting needed care in a timely fashion. The information could also help educate consumers about accepted medical practice and appropriate utilization. For example, if the key information for an appeal is documentation of a more severe condition or symptom, the consumer could choose to talk to her or his provider about alternate (and possibly more appropriate) treatment options or get a second opinion, instead of pursuing an appeal. Either way, having access to this information will enable patients to be more engaged and informed health care consumers.

The commenter recognizes that the proposed rules require URAs to share this information with providers, but asserts that these rules have moved the information key to an appeal from the adverse determination letter to the peer-to-peer call between the URA and provider prior to the adverse determination in §19.1710. The commenter supports the inclusion of this information in the peer-to-peer call and believes this will enable providers to identify and submit any missing or needed documentation quickly, reducing the need for appeals. However, providing this information only to providers is not sufficient. Although appeals for adverse determinations are likely generally conducted by providers on behalf of patients, consumers have a right to appeal adverse determinations and do so. As proposed, these rules empower providers to appeal more effectively, but do not provide the same transparency and knowledge to consumers who appeal adverse determinations. Concerns may be raised that, in some cases, the information URAs would have to provide would be lengthy and complex. That may be true, but does not justify making information critical to a consumer obtaining needed health care difficult or impossible to obtain. Consumers who want to appeal but need help understanding information from the URA can consult with their provider or may be able to enlist other assistance, possibly from TDI's Consumer Protection Division. Including information in the notice that could reverse an adverse determination on appeal would benefit providers as well as consumers. Though providers would have access to this information in a peer-to-peer call, URAs and providers are not always successful at connecting for a peer-to-peer call. Putting the information in the notice would ensure providers get the information even if they cannot connect by phone with the URA.

The commenter asserts that, if TDI does not require information that could help on appeal be included in the notice of adverse determination, it should, at a minimum, require that URAs make the information readily available to consumers on request; and inform consumers of how to request this information from the URA in the notice of adverse determination. The commenter believes TDI has statutory authority to require that information key to an appeal be included in the notice of adverse determination under Insurance Code §4201.303(a). Though this information is not explicitly listed in statute as required in the notice, the statute does not preclude adding other elements to the list of what must be in notices. Providing the information in question that could aid in an appeal, for example, missing lab results, is an extension of the principal reason and clinical basis for the adverse determination, which are listed as required notice elements in Insurance Code §4201.303(a)(1) and (2). TDI has statutory authority to add elements to the adverse determination notice under Insurance Code §4201.003, which provides broad rulemaking authority to implement Insurance Code Chapter 4201.

Agency Response: TDI agrees that this information might be helpful but asserts that it is more efficient for this information to be obtained through the peer-to-peer discussion, rather than through a written notice requirement that might not always be necessary and might impose additional costs on the URA. The requirement to include this information in the peer-to-peer discussion is less onerous than having to document it in the notice of adverse determination, but it still facilitates the discussion of what documentation, if any, might lead to a different utilization review determination, which could prevent unnecessary adverse determinations initially as well as be helpful information on appeal.

Comment: A commenter seeks clarification of §19.2009(b)(6). The commenter would like to know what happens in a case where the URA disagrees with the injured employee that the injured employee's condition is life-threatening and does not immediately forward an adverse determination to an IRO. The commenter asks what the injured employee's recourse would be in such a circumstance.

Agency Response: TDI clarifies that, in all instances of a prospective, concurrent, or retrospective utilization review adverse determination, written notification of the adverse determination by the URA must include a statement that in a circumstance involving an injured employee's life-threatening condition, the injured employee is entitled to an immediate review of the adverse determination by an IRO. Further, the injured employee is not required to comply with procedures for an internal review of the adverse determination by the URA for prospective and concurrent utilization review.

TDI clarifies that under §19.2017(a)(2), an injured employee, the injured employee's representative, or the injured employee's provider of record must determine the existence of a life-threatening condition on the basis that a prudent layperson possessing average knowledge of medicine and health would believe that the injured employee's disease or condition is a life-threatening condition. Paragraph (3) of §19.2017(a) provides that any party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination involving a life-threatening condition is denied by the URA may seek an IRO review. URAs are required under §19.2017 to notify TDI within one working day from the date a request for an IRO review is received. A URA who does not comply with these rules may be subject to administrative penalties for noncompliance. Parties who have concerns about the utilization review process may file a complaint with TDI. A copy of the TDI complaint form can be found on TDI's website.

Title 28 TAC §12.205(f), amended to be effective December 26, 2010, provides additional clarification that nothing in the section prohibits a patient, representative of a patient, or a provider of record from submitting pertinent records to an IRO conducting the independent review. Section 12.205(c) also provides that in instances of life-threatening conditions, the IRO must contact the patient and provider directly for medical information.

Comment: A commenter notes that proposed §19.2009(b) sets forth a lengthy list of written notice requirements for the URA to provide when making an adverse determination. The commenter asserts that the list is inconsistent with the requirements of the Workers' Compensation Act. Labor Code §1305.353 provides five specific notification requirements for the URA when making an adverse determination. The commenter asserts that §19.2009(b) should be modified to remain consistent with the language of the Workers' Compensation Act.

Agency Response: TDI disagrees with the suggested change. The statutory lists are not exhaustive. Insurance Code §1305.353(b) states, "Notification of an adverse determination must include" certain elements and §4201.303(a) states, "Notice of an adverse determination must include" certain elements. These lead-in sentences indicate that TDI does not have authority to exclude one of these statutory requirements, but these statutes do not limit the elements in the notice to only those elements. There is no conflict between §19.2009(b) and Insurance Code §1305.353.

Comment: A commenter notes that the requirement for who signs the release of medical information is limited to the enrollee or the enrollee's legal guardian in §19.1709(b)(8)(B). The commenter suggests that TDI address circumstances in which the enrollee is unable to sign a release or the enrollee has authorized another person to act on their behalf with regard to releases of medical information.

Agency Response: TDI declines to make the suggested changes. TDI clarifies that this requirement is based on Insurance Code §4201.552, which prohibits a URA from disclosing individual medical records, personal information, or other confidential information about a patient obtained in the performance of utilization review without the patient's prior written consent, except as otherwise required by law. Section 4201.552 also requires that if the prior written consent is submitted by anyone other than the patient who is the subject of the personal or confidential information requested, the consent must be dated and contain the patient's signature.

Comment: A commenter requests clarification of §19.2009(c). The commenter asks, if one document can serve to both deny a request and be a peer review report, the doctor reviewing a utilization review (preauthorization, concurrent, or retrospective review) can discuss causation or compensability in a determination letter. This would potentially keep medical necessity and claims issues co-mingled.

Agency Response: TDI clarifies that if a peer review is for the review of the medical necessity and appropriateness of health care services the peer reviewer is performing utilization review and must comply with Chapter 4201 and applicable TDI-DWC rules, including 28 TAC Chapter 180. Title 28 TAC §180.22(g) establishes that peer reviews may be performed for the review of the medical necessity or reasonableness of health care and for any issues other than medical necessity, for example, compensability, and ability of an injured employee to return to work. Section19.2009(c) is only applicable to peer review reports regarding the review of medical necessity or reasonableness of health care. Additionally, the rule does not require a URA to consolidate the notice of adverse determination and the peer review report into one document, but gives the URA the administrative flexibility to consolidate these two documents into one if it is appropriate.

Comment: A commenter notes that §19.1709(d)(3) uses the phrase "date of request." The commenter suggests that TDI add to this subsection (or to the "definitions" section in §19.1703) a definition for "date of request" that addresses how requests received after-hours, on weekends, and on state approved holidays are treated differently from requests received during normal business hours.

Agency Response: TDI declines to make the suggested change. TDI clarifies that if the request is received outside of the period requiring the availability of appropriate personnel, the determination must be issued and transmitted within the required timeframes calculated from the beginning of the next time requiring such personnel, and must comply with Insurance Code §4201.302 and §4201.304 timeframes. The URA must also provide the commissioner with the procedures used when responding to poststabilization care subsequent to emergency treatment under Insurance Code §4201.004.

Comment: A commenter expressed confusion regarding the timeframes required under §19.1709, three working days (under Insurance Code §4201.304) versus §19.1718, three calendar days (under Insurance Code §843.348 and §1301.135). It would be helpful if the rules specifically addressed which sections apply and which sections do not or no longer apply in different situations, such as when a URA is providing utilization review services to an HMO or preferred provider benefit plan regarding requests from network providers and requests from non-network providers. In addition, it would be helpful to cross reference 28 TAC §21.2826, which provides that §843.348 and §1301.135 (and thus §19.1718) do not apply to services provided by an HMO or preferred provider benefit carrier to Medicaid and CHIP enrollees.

Agency Response: The timelines for Health Maintenance Organization and Preferred Provider Benefit Plans regarding responses for network and non-network providers are statutory. TDI clarifies that §19.1709 does not apply to CHIP in accord with 28 TAC §21.2826.

§19.1710 and §19.2010. Requirements Prior to Issuing Adverse Determination.

Comment: A commenter asserts that it is unreasonable and unnecessary to mandate that the URA must discuss "a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review." The proposed mandate would require the URA to engage in speculation of what might lead to a different decision during a future appeal. The URA's responsibility and obligation is to review whether the specific health care service provided, or proposed to be provided, to the injured employee is clinically appropriate, effective, and provided in accord with best practices consistent with evidence-based medicine. If the URA makes an adverse determination, then the URA is statutorily obligated under Labor Code §1305.353 to provide the principal reasons and clinical basis for the adverse determination, the screening criteria used during the review and a description of the reconsideration and independent review process. The URA is not obligated to speculate about what might be done differently for a different result to occur during a future appeal and, indeed, such speculation is not part of utilization review. The commenter asserts that the language "and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision" in the initial paragraph of proposed §19.2010 should be deleted.

A commenter asserts that the broad requirement for adverse determinations for prospective or concurrent utilization review to list "a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision" requires a URA to speculate as to all possible variables that might affect the decision regardless of the likelihood of whether or not any such documents or evidence exists, shifting evidentiary responsibilities. The rule is potentially highly burdensome when combined with the possibility of sanctions or reversal upon a subjective determination of failure to comply with the rule.

A commenter asserts that it is the responsibility of the requesting provider to submit the necessary documentation to substantiate the need for the requested medical treatment. It would be impossible for the commenter to cover every possible medical scenario which could potentially result in circumstances leading to an authorization. The Official Disability Guidelines (ODG) has crafted an entire appendix (Appendix D), titled "Documenting Exceptions to the Guidelines" specifically for this purpose. It is not and should not be the responsibility of the URA to provide this to the requesting provider.

Additionally, the commenter requests that the word "physician" be changed to "healthcare provider."

A commenter objects to the requirement in this definition and §19.1710 that a reasonable opportunity for the provider of record to discuss the plan of treatment with a physician prior to issuing an adverse determination in a retrospective situation. In an instance in which a service has already been provided, there is no regulatory rationale for providing the opportunity for a peer-to-peer discussion prior to issuing an adverse determination. It would be more cost-effective to require a peer-to-peer consultation for retrospective utilization review only in those instances in which the provider of record makes such a request upon receipt of the notice of adverse determination. This solution accomplishes the goal of allowing a peer-to-peer review when a provider of record desires a review, without adding unnecessary expense to the process when a provider of record may not desire a peer-to-peer review. The commenter urges TDI to revise the rules to require peer-to-peer consultation only when the provider of record requests such consultation within a reasonable time of receiving the notice of adverse determination.

A commenter explains that retrospective review is a review of multiple services and providers for services that already took place. The commenter requests clarification of the purpose of calling a provider who may or may not still be treating an injured employee to discuss what they already did, which was either not documented appropriately or not within the treatment guidelines. Whatever the case may be, they cannot go back and change it as it already took place. Additionally, the commenter asks when the call takes place. At the time the insurance carrier requests the retrospective review, the reviewing provider does not know what the carrier will be doing with the information obtained. It might be used just for the adjuster's information, making an attempt for peer-to-peer discussion to provide an opinion based on the records reviewed is unreasonable and time consuming.

Agency Response: TDI declines to make the suggested deletion. TDI believes the information is important and has added a requirement to include this information in the peer-to-peer discussion under adopted §19.1710 and adopted §19.2010. The last sentence of the introductory language of each of these sections states, "The discussion must include, at a minimum, the clinical basis for the utilization review agent's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision." The requirement to include this information in the peer-to-peer discussion is less onerous than having to document it in the notice of adverse determination, but it still facilitates the discussion of what documentation, if any, might lead to a different utilization review determination, which could be helpful information on appeal.

In response to the request to change the term "physician" to "health care provider," TDI clarifies that the first sentence in §19.2010 tracks Insurance Code §4201.206, and so, TDI declines to make the suggested change.

As previously discussed, HB 4290 amends the definition of the term "utilization review" in §4201.002(13) of the Insurance Code to specifically include "retrospective review." Insurance Code §4201.206 provides that, subject to the notice requirements of Subchapter G of Chapter 4201, before an adverse determination is issued by a URA who questions a health care service on the basis of medical necessity or appropriateness or the experimental or investigational nature of the service, the URA must provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination.

Comment: A commenter believes that §19.2010 is inappropriate and should be deleted prior to the rule being adopted. The health care provider who proposed to or has rendered healthcare services to an injured employee has the burden to substantiate the medical necessity and appropriateness of proposed or rendered healthcare services. Neither the Labor Code nor the Insurance Code require an insurance carrier or a URA to provide a health care provider with a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision. The commenter asserts that this rule provision exceeds TDI's statutory authority as it relates to the regulation of utilization review.

A commenter respectfully requests that the language "dentist, chiropractor or other appropriate health care provider" be added to the end of the first sentence after the word "physician." The commenter requests that the language "and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision" be deleted. The commenter also requests that the words "an appropriate" be added to describe the telephone number that must be provided under proposed §19.2010(a)(1).

Agency Response: TDI agrees in part and disagrees in part. TDI declines to make the suggested deletion, because, as previously discussed, the requirement to include this information in the peer-to-peer discussion facilitates the discussion of what documentation, if any, might lead to a different utilization review determination, which could prevent unnecessary initial adverse determinations as well as be helpful information on appeal.

TDI agrees to add the suggested language to the introductory paragraph, in part, to include a dentist or chiropractor in the reasonable opportunity for discussion with the provider of record prior to issuance of an adverse determination. TDI declines to add "or other appropriate health care provider." Insurance Code §4201.206 establishes that the peer-to-peer discussion before an adverse determination is issued must be with a physician. However, Labor Code §408.0044 and §408.0045 are also ap-

plicable, so dentist or chiropractor have been added as recommended by the commenter.

Comment: A commenter strongly supports the last sentence in the initial paragraph of §19.1710 and §19.2010 that includes "a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision." As was stated by TDI in the July 8, 2011, Texas Register when proposing §19.1710(c)(1)(D) which has similar language to §19.1710, "the additional notice element relating to helpful documentation or evidence that can be submitted upon appeal of the adverse determination, is important for the patient to understand what evidence or documentation the provider of record will need to submit." That reasoning is still valid and supports the adoption of this provision of the rule with the inclusion of a written notice to the enrollee.

Agency Response: TDI appreciates the supportive comment, but declines to make the suggested change. TDI believes the information is important and has added a requirement to include this information in the peer-to-peer discussion under adopted §19.1710 and adopted §19.2010. The requirement to include this information in the peer-to-peer discussion is less onerous than having to document it in the notice of adverse determination, but it still facilitates the discussion of what documentation, if any, might lead to a different utilization review determination, which could be helpful information upon appeal.

Comment: A commenter recommends adding the following language to the beginning of proposed §19.1710 "In any instance in which the URA that is authorized to and deny authorization or reimbursement for health care..."

Agency Response: TDI declines to add the suggested language. The requirement to provide an opportunity to discuss treatment before an adverse determination tracks Insurance Code §4201.456, and the addition of the suggested language would not be consistent with statutory language.

Comment: A commenter supports the requirement that the peer-to-peer call include a description of documentation or evidence, if any, that can be submitted that might lead to a different utilization review decision. The commenter recommends that the wording in this section be changed to clarify that the documentation or evidence in question could be provided to possibly "prevent" an adverse determination, as opposed to leading to a different determination "upon appeal." The commenter hopes that by requiring URAs and physicians to discuss this evidence before an adverse determination is made, physicians will be able to submit needed information prior to an adverse determination and appeals can be avoided altogether in some cases. The commenter asserts that consumers, who have every right to appeal and do so, also need access to information on what evidence could possibly make their appeal more successful.

Agency Response: TDI appreciates the supportive comment, but declines to make the suggested change. By specifying minimum elements, the proposed rules clarify that the required discussion may also include other matters as deemed necessary by the URA or provider of record. Additionally, the discussion could prevent an adverse determination because the reasonable opportunity for discussion occurs before an adverse determination is issued. The suggested language would not add any clarity to the rules.

Comment: A commenter would like to see further clarification of what the information required in §19.2010(2) will look like so systems can be programmed to populate this information. The commenter states that perhaps it can be a standard like the information that is currently sent in March annually.

Agency Response: TDI declines to further clarify how the URA is required from a logistical standpoint to program their systems with the information required to be submitted to TDI on request. Section 19.2010(2) provides that the URA must maintain, and submit to TDI or TDI-DWC on request, documentation that details the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome.

Comment: A commenter supports the requirement that the URA maintain documentation detailing the discussion opportunity provided to the provider of record, whether a discussion took place, and the outcome. The commenter also supports the requirement that URAs submit the required documentation to TDI on request. These steps will allow TDI to track compliance and likely increase the likelihood that URAs and providers are able to connect for peer-to-peer calls, which will help consumers get appropriate health care.

Agency Response: TDI appreciates the supportive comment.

§19.1711 and §19.2011. Written Procedures for Appeal of Adverse Determinations.

Comment: A commenter notes that it appears in §19.1711(a)(3)(D) that receipt of the written appeal form by the URA is a prerequisite for the URA to process an oral appeal. The commenter requests that TDI confirm this in the adoption order.

Agency Response: TDI clarifies that adopted §19.1711(a)(3)(D) tracks Insurance Code §4201.355. Receipt of a written appeal form by the URA is not a prerequisite to process an oral appeal. Insurance Code §4201.354 provides, in part, that an adverse determination may be appealed orally or in writing.

Comment: A commenter recommends that the deadlines for appealing the initial determination of the URA and for requesting IRO review of the second adverse determination be specifically identified in §19.2011(a)(1) and (2) and §19.2011(a)(8)(A) and (B). The proposed URA rules are lengthy and complex and should include all the information related to the process rather than referencing other rule sections. This change would ensure that system participants could more readily determine their responsibilities under the rules.

Agency Response: TDI declines to delete the references to other codes and rules because URAs are required to comply with the cited rules and statutes, and inclusion of the entire text of other rules and statutes would be repetitive. TDI has determined that the rules are more streamlined and easier to understand by including cross-references, and URAs are on notice that they are subject to the requirements in other rules and statutes.

Comment: A commenter notes that it appears in §19.1711(a)(5) that the opportunity for a peer-to-peer discussion is now being contemplated on appeals of adverse determinations. The commenter objects to this requirement, and question the statutory authority for this requirement on the appeal level. A peer-to-peer opportunity has already been provided prior to issuing the adverse determination and the rationale for such an opportunity no longer exists on appeal. The commenter requests that this requirement be deleted.

A commenter asserts that if TDI intended to use the language of §19.1711(a)(5) to impose a requirement on a URA to provide a second "reasonable opportunity" to have a peer-to-peer discussion with the same provider of record as part of the appeal process, the commenter objects to the inclusion of such a step, which would be repetitive and unduly burdensome. In the introductory discussion, TDI seems to indicate that the rules as proposed to require a peer-to-peer discussion opportunity for an appeal, "consistent with §4201.206." Insurance Code §4201.206 specifically references Subchapter G, which is limited to initial determinations, while the appeal process is addressed under Subchapter H. Subchapter G does not address appeal requirements, so §4201.206 is not an appropriate basis for creating a new peer-to-peer requirement for appeals. There is no statutory authority for imposing such a new requirement.

Agency Response: TDI clarifies that this discussion is a second peer-to-peer discussion. Insurance Code §4201.206 does not limit the peer-to-peer discussion requirement to initial adverse determinations. It requires the peer-to-peer discussion "before an adverse determination is issued by a utilization review agent." A denial of an appeal of an initial adverse determination is also considered an adverse determination.

Comment: A commenter asserts that there is no legislative authority supporting a blanket prohibition on the same doctor reviewing his or her previous adverse determination on appeal in §19.2011(a)(4). The authorities cited in support limit any such prohibition to certain circumstances and even if taken altogether, do not comprise a blanket prohibition.

A commenter asserts that §19.2011(a)(4) establishes what must, as a minimum, be included in a URA's written procedures for appeal of adverse determinations. The commenter asserts that the subsection limits who may make a decision on behalf of the URA on appeals of adverse determinations to physicians, dentists, or chiropractors who have not previously reviewed the case. The subsection ignores the provisions of other URA rules that provide for the review of healthcare by other appropriate healthcare providers. The commenter asserts that the words "or other appropriate healthcare provider" be added to §19.2011(a)(4) and (a)(5).

A commenter notes that §19.1711(a)(5) states, "In any instance in which the URA is questioning the medical necessity or appropriateness . . . prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment . . .". If this sentence is intended to speak of procedures to be followed "prior to issuance of an adverse determination," it should be moved to §19.1710 of these rules (Requirements Prior to Issuing Adverse Determination).

Agency Response: TDI declines to make the suggested changes. TDI clarifies that this provision is consistent with Insurance Code §4201.356(a), which provides that the procedures for appealing an adverse determination must provide that a physician makes the decision on the appeal, except as provided by §4201.356(b) relating to specialty provider reviews.

TDI also clarifies that §19.1711(a)(5) provides the requirements of a URA's written procedures for appeals.

Comment: A commenter supports §19.2011(a)(5) and appreciates its inclusion in the proposed rule.

Agency Response: TDI appreciates the supportive comment.

Comment: A commenter asserts that, to stay consistent with the use of the term "provider of record", §19.1711(a)(6) should be changed to reflect "provider of record" and not "health care provider."

Agency Response: TDI declines to make the suggested change. This provision is consistent with Insurance Code §4201.356(b), relating to specialty provider reviews.

Comment: A commenter asserts that §19.1711(a)(7)(A) should be clarified to assure that the health care provider performing the review is not only the same or similar specialty as the health care provider that typically manages the medical condition, procedure, or treatment under review but also of the same licensure. This matches the reviewer with similar statutory requirements for education, training, and standards as the provider of record who has performed the service. The commenter suggests that the words "of the same licensure as the requesting health care provider" be added to §19.1711(a)(7)(A).

Agency Response: TDI declines to make the suggested change. This provision is consistent with Insurance Code §4201.357(a), relating to expedited appeal for denial of emergency care or continued hospitalization.

Comment: A commenter asserts that proposed §19.2011(a)(7)(C) strongly implies that all URA reviewers making adverse determinations are required to have a medical specialty. The commenter recommends that the language be changed to add "if any" after the words "professional specialty."

Agency Response: TDI declines to make the suggested change. This provision is consistent with Insurance Code §4201.357(a), relating to expedited appeal for denial of emergency care or continued hospitalization.

Comment: A commenter asserts that §19.2011(a)(9) has no applicability in the workers' compensation context. The Workers' Compensation Act already provides that health care provided in medical emergencies is not subject to prospective review under Labor Code §413.014. A URA may perform utilization review for medical emergency services only on a retrospective basis. Expedited review is not necessary for a retrospective review determination. The commenter asserts that proposed §19.2011(a)(9) should be withdrawn.

Agency Response: TDI declines to make the suggested deletion. This provision is consistent with Insurance Code §4201.360. Section 19.2011(a)(9) also provides that in a circumstance involving a request for a medical interlocutory order under 28 TAC §134.550, the injured employee is entitled to an immediate review by an IRO of the adverse determination.

Comment: A commenter asserts that the term "life-threatening" in §19.2011(a)(9) is borrowed from statutory requirements for health insurance and health benefit plans. However, the Texas Workers Compensation Act does not use that term but instead utilizes the term "emergency" which has broader meaning and application. Labor Code §413.014 and Insurance Code §1305.351 expressly exempt emergency treatment and services from preauthorization. The commenter asserts that 28 TAC §134.600 exempts emergency medical treatment and services from prospective and concurrent utilization review requirements. Interjecting that term into the workers' compensation rules could mislead stakeholders into believing that the expedited utilization review and appeal provisions for life-threatening conditions covered by health insurance and health benefit plans also applies to workers' compensation. This can be bad for workers

if emergency medical care for a life-threatening condition is delayed in order to obtain unnecessary preauthorization or concurrent medical review. For example, a convenience store cashier who receives a gunshot wound to the chest in the course and scope of employment does not and should not be required to obtain preauthorization and concurrent medical review for the inpatient hospitalization and surgery that is necessary to save the cashier's life. A hospital that is aware of the "life-threatening" conditions provisions in the workers' compensation rules may be erroneously led to believe that preauthorization or concurrent review by the URA or IRO is necessary before it can admit the patient and perform surgery. Likewise, a carrier bill reviewer who is aware of the "life-threatening" conditions provisions in the workers' compensation rules may erroneously decide that the hospital is not entitled to reimbursement for the hospital admission and surgery if the medical or claims records reflect that no preauthorization or concurrent review was obtained prior to admission and surgery. The only time that a URA or IRO is supposed to perform utilization review of medical treatment rendered for a life-threatening condition is retrospective utilization review after the services have already been rendered. No expedited review process is necessary for retrospective review. The commenter asserts that §19.2011(a)(9) should be deleted.

Agency Response: TDI declines to make the suggested deletion. These rules implement statutory provisions of Insurance Code Chapter 4201. Insurance Code §4201.303(b) provides that for an enrollee who has a life-threatening condition, the notice of an adverse determination must include a description of the enrollee's right to an immediate review by an IRO and of the procedures to obtain that review. Insurance Code §4201.360 provides that, notwithstanding any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an IRO and is not required to comply with procedures for an internal review of the URA's adverse determination.

The terms "life-threatening" and "medical emergency" overlap in certain circumstances, but are not synonymous. The term "life-threatening," under Insurance Code §4201.002(7), is a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. There is no requirement that the likelihood of death is imminent or the condition is acute. The terms "emergency care," under Insurance Code §4201.002(2), and "medical emergency," under Insurance Code §1305.004(13), both require the condition to be of recent or sudden onset, respectively, and requiring immediate medical care or attention, in part, to avoid placing the individual's health in serious jeopardy. Section 19.2003(18) also contains a separate definition of "medical emergency" that tracks the definition in Insurance Code §1305.004(a)(13) with a clarifying change from the use of the term "patient" to the term "injured employee."

The concept of "life-threatening" conditions may also be found in the workers' compensation system in the IRO regulations under 28 TAC §12.5, which defines "life-threatening condition," and §12.205 and §12.206, which contain requirements specific to instances of life-threatening conditions. TDI is not introducing a new concept in these rules. For example, 28 TAC §133.305 also defines "life-threatening," and 28 TAC §133.308(h) provides that in a preauthorization or concurrent review dispute request, an injured employee with a life-threatening condition is entitled to an immediate review by an IRO and is not required to comply with procedures for a reconsideration.

Additionally, Labor Code §413.014, Insurance Code §1305.351, and 28 TAC §134.600 exempt emergency treatment and services from prospective and concurrent utilization review, but it is not TDI's intent to apply the requirements regarding life-threatening conditions to emergency treatment.

Comment: A commenter notes that §19.1711(c) is titled "Appeals concerning an acquired brain injury" but the language seems to reference initial requests or extension requests. It is not clear whether the three business day timeframe applies to appeals. If TDI wants to create a special timeframe for the acquired brain injury service appeals, then the commenter's recommendation is to make the language more clearly related to appeals, by adding "Not later than three business days after the date on which an individual requests a utilization review appeal, a URA must . . ."

Agency Response: TDI declines to make the suggested change. TDI clarifies that a URA must make a determination concerning an acquired brain injury no later than three business days after the date an individual requests utilization review or an extension of coverage based on medical necessity or appropriateness. The URA must provide notification of the determination through a direct telephone contact to the requestor. This provision is consistent with Insurance Code §1352.006.

§19.1712. URA's Telephone Access; and §19.2012. URA's Telephone Access and Procedures for Certain Drug Requests and Post-Stabilization Care.

Comment: Commenters note that proposed §19.2012(b) addresses procedures for responding to requests for drugs that require preauthorization, post-stabilization care, and pain management medication immediately subsequent to surgery or emergency treatment, as requested by the treating physician or provider of record.

The commenters assert that this subsection was inappropriately included in the rule as it is basically a closed prescription drug formulary implementation issue. Additionally, this type of activity does not occur currently in the Texas workers' compensation system. There is no requirement for such a rule provision set out in either the Insurance Code or the Labor Code. The closed prescription drug formulary rules adopted by the commissioner of workers' compensation in TAC Chapter 134 should address the concerns related to the provisions of this subsection.

The commenters request that this subsection be deleted and that TDI-DWC take appropriate action to address this issue in the closed drug formulary rules.

Agency Response: TDI declines to make the suggested deletion. The requirement in §19.2012(b) is necessary to complement the pharmacy closed formulary rules in 28 TAC Chapter 134, Subchapter F, for both certified network and non-network claims in workers' compensation. Section 134.550 provides a prescribing doctor or pharmacy with the ability to obtain a medical interlocutory order in certain instances in which preauthorization denials of a previously prescribed and dispensed drug excluded from the closed formulary poses an unreasonable risk of a medical emergency as defined in 28 TAC §134.500(7) and Insurance Code §1305.004(a)(13). The purpose of new §19.2012(b) is to require the URA to have specific procedures for these high-risk situations.

Comment: A commenter asks for clarification as to why §19.2012(b) is in the telephone access section. The commenter states that the treating doctor or consulting doctor, as appro-

priate, would have responsibility to ensure that requests for drugs that require preauthorization are made. For example, if the injured employee has a 30 day script; they would ask for preauthorization on the 25th day to ensure the preauthorization process is completed prior to expiring. For post-stabilization care this should be part of the request for surgery and, for emergency treatment, this does not require preauthorization for an injured employee. The commenter suggests these two areas can be addressed somewhere other than in the telephone access section and asks that, if TDI disagrees, to provide an example of an acceptable solution.

A commenter asserts that §19.2012 does not relate to utilization review. Instead, the topic relates to implementing the closed drug formulary. The activity described is not utilization review and the proposed mandate is not in the Texas Insurance Code or the Workers' Compensation Act. The commenter asserts that §19.2012 should be withdrawn.

Agency Response: TDI clarifies that the title of the section is URA's Telephone Access and Procedures for Certain Drug Requests. TDI added the phrase "and Post-Stabilization Care" to accurately reflect the content of the section.

TDI clarifies that §19.2012(b) requires a URA to have and implement procedures when responding to two types of requests. The procedures must address requests for drugs that require preauthorization if the injured employee has received or is currently receiving the requested drugs and an adverse determination could lead to a medical emergency. They also must address requests for post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment as requested by a treating physician or provider of record.

The requirement in §19.2012(b) is necessary to complement the pharmacy closed formulary rules in 28 TAC Chapter 134, Subchapter F, for both certified network and non-network claims in workers' compensation. Section 134.550 provides a prescribing doctor or pharmacy with the ability to obtain a medical interlocutory order in certain instances in which preauthorization denial of a previously prescribed and dispensed drug, excluded from the closed formulary, poses an unreasonable risk of a medical emergency as defined in 28 TAC §134.500(7) and Insurance Code §1305.004(a)(13). Subchapter R rules do not have an equivalent requirement because the pharmacy closed formulary rules do not apply to health care provided under a health benefit plan or health insurance policy. The purpose of new §19.2012(b) is to require the URA to have specific procedures for high-risk situations.

§19.1713 and §19.2013. Confidentiality.

Comment: A commenter asserts that, in contrast to §19.2013(a)(4), other rules permit health care providers to charge insurance carriers and URAs 50 cents per copied page. The same maximum charge should apply to health care providers' requests for copying as well as copies produced by health care providers. Either URAs should be able to charge health care providers 50 cents per page or existing rules should be modified to require that health care providers not charge insurance carriers and URAs more than 10 cents per copied page.

A commenter questions the 10 cents per page charge limit given the fact other rules allow physicians to charge insurance carriers and URAs 50 cents per page. The commenter asserts that there is no justification for such a discrepancy. The commenter requests TDI delete "10" and replace it with "50."

Agency Response: TDI declines to make the suggested change. The provision tracks the limitation on a URA's charges for providing a copy of recorded personal information to individuals in existing §19.2014(e).

§19.1714 and §19.2014. Regulatory Requirements Subsequent to Certification or Registration.

Comment: A commenter notes that in §19.2014(c)(3), the "and" should be replaced with an "or" in the proposed rule as the rule lists examples and is not exhaustive.

Agency Response: TDI agrees to make the suggested change for clarity and consistency with adopted §19.1714(c)(3).

Comment: A commenter requests that TDI discuss in its rule adoption preamble that unscheduled on-site reviews under §19.2014(g)(2) will not be conducted as a normal course of TDI's business practices and will be restricted to instances where there is reasonable suspicion of criminal or other inappropriate activity that precludes the need for prior notice of an on-site review.

Agency Response: TDI declines to further restrict unscheduled on-site reviews and clarifies that unscheduled on-site reviews are conducted by TDI as deemed necessary for the public good or for a proper discharge of its duties.

Comment: A commenter raises a variety of concerns about proposed §19.2014(g). A commenter did not see any grant of authority for TDI to make unannounced on-site reviews of utilization review agents' operations in HB 4290. The commenter did not see any grant of authority for TDI to make unannounced visits to an URA's place of business to demand and seize records relating to operations by the URA.

The commenter's review of the Insurance Code did not reveal any requirement that an insurance carrier or URA waive its constitutional rights to obtain a certificate, license, or permit to do business in Texas. The commenter notes that the grant of free access to books and records is not the same as a grant of free access to the place of business of a carrier or URA to demand to see their operations, books and records, and to seize the books and records. The commenter believes that the unannounced on-site visits to review operations, review books and records, and possibly seize the books and records as proposed by TDI, are in violation of other laws and would be invalid if adopted. In addition, the commenter asserts proposed subsection (g) of §19.2014 conflicts with subsection (e) of §19.2014 which gives the URA ten days to respond to "an inquiry." According to subsection (g), the URA must make available all records relating to its operation during any scheduled or unscheduled on-site reviews. The commenter notes that, at a minimum, this conflict should be addressed if TDI adopts §19.2014 as proposed.

Agency Response: TDI disagrees that the adopted rules pertaining to unannounced visits are invalid because they are based on a statute that violates Article 1, §9, and §29 of the Texas Constitution and the Fourth Amendment to the United States Constitution.

The provision for TDI to perform on-site reviews may be found in existing §19.2016(h), adopted to be effective September 20, 1998, which provides that URAs will be notified by letter providing the identity of the commissioner's designated representative and the expected arrival date and time. Adopted §19.2014(g) clarifies that the on-site reviews may be unscheduled, and that the notice will be in writing and presented by TDI's designated representative on arrival.

Insurance Code §4201.601 authorizes TDI to take certain steps if it believes that a person or entity conducting utilization review is in violation of Chapter 4201 or applicable rules. These steps include authority to compel the production of necessary information if it believes that the URA is in violation of Insurance Code or rules relating to reasonable accessibility.

TDI has rulemaking authority under Insurance Code §36.001 and §4201.003 to adopt this requirement.

§19.1716 and §19.2016. Specialty URA.

Comment: A commenter requests an explanation of when a specialty URA would be required and whether that determination itself is subject to challenge and review under §19.2016.

Agency Response: TDI clarifies that Insurance Code §4201.451 provides that, for purposes of this subchapter, "specialty utilization review agent" means a utilization review agent who conducts utilization review for a specialty health care service, including dentistry, chiropractic services, or physical therapy. Specialty review agents are subject to adopted §19.2017, regarding independent review of adverse determinations. Insurance Code §4201.452, regarding inapplicability of certain other law, provides that a specialty utilization review agent is not subject to §§4201.151, 4201.152, 4201.206, 4201.252, or 4201.356. Additionally, §19.1716(b) and §19.2016(b) require a specialty URA to conduct utilization review under the direction of a health care provider who is of the same specialty as the agent and who is licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the U.S. For example, when conducting utilization review of prescription drugs prescribed by a physician with a specialty in neurological surgery, the specialty URA must be a physician with a specialty in neurological surgery. This provision tracks the requirements in Insurance Code §4201.454 and is consistent with Insurance Code §1305.351(d) and Labor Code §408.023(h).

Comment: A commenter strongly supports the language in §19.1716 and §19.2016 concerning a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision is included. The commenter also recommends that a written notice of such adverse determination be provided to the injured employee or enrollee.

Agency Response: TDI appreciates the supportive comment but declines to add the requirement that description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision be included in the written notice of adverse determination. As previously discussed, the requirement to include this information in the peer-to-peer discussion is less onerous than having to document it in the notice of adverse determination, but it still facilitates the discussion of what documentation, if any, might lead to a different utilization review determination, which could be helpful information upon appeal.

Comment: A commenter expresses concern over §19.2016(g). The commenter notes that the broad requirement for adverse determinations for prospective or concurrent URA to list a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision requires a URA to speculate as to all possible variables that might affect the decision regardless of the likelihood of whether or not any such documents or evidence exists, shifting evidentiary responsibilities. The rule is potentially highly burdensome when combined with the possibility of sanctions or reversal on a subjective determination of the URA's failure to comply with the rule.

Agency Response: TDI declines to make the suggested deletion of the requirement that a URA include a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision. TDI believes the information is important and has added a requirement to include this information in the peer-to-peer discussion under adopted §19.2016(g) and adopted §19.2010(a) The requirement to include this information in the peer-to-peer discussion is less onerous than having to document it in the notice of adverse determination, but it still facilitates the discussion of what documentation, if any, might lead to a different utilization review determination, which could potentially prevent unnecessary adverse determinations in the first place as well as provide helpful information upon appeal.

Comment: A commenter asserts that there is no legislative authority supporting a blanket prohibition on the same doctor reviewing his or her previous adverse determination on appeal in proposed §19.2016(h).

Agency Response: TDI declines to make the suggested change. This provision is consistent with Insurance Code §4201.356(a), which provides that the procedures for appealing an adverse determination must provide that a physician makes the decision on the appeal, except as provided by §4201.356(b) relating to specialty provider reviews. Insurance Code §4201.003(a) grants the commissioner general rulemaking authority to implement Insurance Code Chapter 4201.

§19.1717 and §19.2017. Independent Review of Adverse Determinations.

Comment: A commenter asserts that proposed §19.2017(a) attempts to create a process for addressing adverse determinations when an injured employee is faced with a "life-threatening condition." The commenter asserts that the introduction of the "life-threatening condition" term and concept is inappropriate for these rules. The term "life-threatening condition" is borrowed from statutory requirements for health insurance and health benefit plans. The Texas Workers' Compensation Act does not use that term but instead utilizes the term of "emergency," which has broader meaning and application. The inclusion of this subsection would create a new utilization review process that is not appropriate for workers' compensation claims, because Labor Code §413.014 and Insurance Code §1305.351 expressly exempt emergency treatment and services from preauthorization. Likewise, 28 TAC §134.600 exempts emergency medical treatment and services from prospective and concurrent utilization review requirements. The commenter asserts that it is inappropriate to create a process for the independent review of adverse determinations regarding treatment for which a life-threatening condition or medical emergency exists because Labor Code §413.014 and Insurance Code §1305.351 expressly exempt emergency treatment and services from preauthorization.

Commenters request that proposed §19.2017(a) be deleted.

Agency Response: TDI declines to make the suggested deletion. See TDI's response earlier to §19.2011(a)(9). Section 19.2017(a) provides, in part, that for life-threatening conditions, notification of adverse determination by a URA must be provided within the timeframes specified in §19.1709(d)(3) of this title (relating to Notice of Determinations Made in Utilization Review).

Comment: A commenter asserts that §19.2017(b) shifts the responsibility to the URA and conflicts with 28 TAC §133.308(h), which states, "Timeliness. A requestor shall file a request for independent review with the insurance carrier that actually issued the adverse determination or the insurance carrier's utilization review agent (URA) that actually issued the adverse determination no later than the 45th calendar day after receipt of the insurance carrier's denial of an appeal. The insurance carrier shall notify TDI of a request for an independent review within one working day from the date the request is received by the insurance carrier or it's URA. In a preauthorization or concurrent review dispute request, an injured employee with a life-threatening condition, as defined in §133.305 of this subchapter (relating to MDR General), is entitled to an immediate review by an IRO and is not required to comply with the procedures for an appeal to the insurance carrier." The commenter recommends this section be changed to mirror the section of the Texas Administrative Code noted above, which places the responsibility on the insurance carrier or the URA.

Agency Response: TDI agrees to make the suggested change. TDI made revisions requiring the independent review request form LHL009 to be returned to the entity that issued the adverse determination, whether the carrier or the URA. TDI revised adopted §19.2017(b), to state, "A URA, or insurance carrier that made the adverse determination, must notify TDI within one working day from the date a request for an independent review is received. The URA, or insurance carrier that made the adverse determination, must submit the completed request for a review by an IRO form to TDI through TDI's internet website."

Comment: A commenter seeks clarification of §19.2017(a)(2), and is concerned with the result if the URA disagrees with the injured employee's determination that a condition is life-threatening and how such a disagreement would be reviewed.

Response: TDI clarifies that in all instances of a prospective, concurrent, or retrospective utilization review adverse determination, written notification of the adverse determination by the URA must include a statement that in a circumstance involving an injured employee's life-threatening condition, the injured employee is entitled to an immediate review of the adverse determination by an IRO. The injured employee is not required to comply with procedures for an internal review of the adverse determination by the URA for prospective and concurrent utilization review.

The new requirement under §19.2017(a)(2) is necessary to clarify that a health care provider does not have to make the determination that the condition is life-threatening, which provides more flexibility to the injured employee as long as the prudent layperson test is met. Insurance Code §4201.002(7) defines "life-threatening" as a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The statute does not specify who is required to make the determination that the disease or condition is life-threatening. TDI interprets this provision broadly to allow determination of the existence of a life-threatening condition based on a prudent layperson standard, rather than more narrowly to allow only medical personnel to make the determination. Under this interpretation, an injured employee who cannot obtain a medical opinion that his or her condition is life-threatening may still be entitled to a faster notice of adverse determination and immediate access to independent review. This requirement is proposed under TDI's rulemaking authority in Insurance Code §4201.003 to adopt rules to implement Chapter 4201.

TDI clarifies that under §19.2017(a)(2), an injured employee, the injured employee's representative, or the injured employee's provider of record must determine the existence of a life-threatening condition on the basis that a prudent layperson possessing average knowledge of medicine and health would believe that the injured employee's disease or condition is a life-threatening condition. Paragraph (3) of §19.2017(a) states that any party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination involving a life-threatening condition is denied by the URA may seek an IRO review. URAs are required under §19.2017 to notify TDI within one working day from the date a request for an IRO review is received. A URA who does not comply with these rules may be subject to administrative penalties for noncompliance. Parties who have concerns about the utilization review process may file a complaint with TDI. A copy of the TDI complaint form can be found on TDI's website.

Title 28 TAC §12.205(f), amended to be effective December 26, 2010, provides additional clarification that nothing in the section prohibits a patient, representative of a patient, or a provider of record from submitting pertinent records to an IRO conducting independent review. Section 12.205(c) also provides that in instances of life-threatening conditions, the IRO must contact the patient and provider directly for medical information.

Comment: A commenter strongly supports §19.2017(a)(2), which would permit an individual acting on behalf of the injured worker, or the injured worker's provider of record, to determine the existence of a life-threatening condition on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the injured worker's disease or condition is a life-threatening condition. This will minimize delay when a delay can be harmful or even deadly to the patient. The rule also conforms to the "prudent layperson" standard as is defined under Insurance Code §4201.002. The provision enables and benefits the injured worker and a person acting on behalf of the enrollee in accessing the care that is necessary to prevent further injury and perhaps even death.

A commenter supports §19.1717(a)(2), which will permit an enrollee, person acting on behalf of an enrollee, or the enrollee's provider of record to determine the existence of a life-threatening condition on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the enrollee's disease or condition is a life-threatening condition. This standard is reasonable and appropriate, especially considering that enrollees and people acting on their behalf have the right to appeal and will have to make this determination. This standard will help ensure access to necessary care in a timely matter when time is of the essence.

Agency Response: TDI appreciates the supportive comments.

Comment: A commenter asserts that proposed §19.2017(a)(9) is in conflict with 28 TAC §133.308(h), which provides that a requestor must file a request for independent review with the insurance carrier that actually issued the adverse determination or the insurance carrier's URA that actually issued the adverse determination no later than the 45th calendar day after receipt of the insurance carrier's denial of an appeal. The rule also provides that the insurance carrier shall notify TDI of a request for an independent review within one working day from the date the request is received by the insurance carrier or URA. The commenter requests that the rule be amended by deleting "Independent review involving life-threatening and non-life threatening conditions," and by adding the language "must file a request

for independent review with the insurance carrier that actually issued the adverse determination or the insurance carrier's URA that actually issued the adverse determination no later than the 45th calendar day after receipt of the insurance carrier's denial of an appeal. The insurance carrier shall notify TDI of a request for an independent review within one working day from the date the request is received by the insurance carrier or URA." The commenter suggests deleting the language "TDI within one working day from the date a request for an independent review is received."

Agency Response: TDI declines to make the suggested change to §19.2017(b), and clarifies that the suggested language is contained in §19.2009(b)(9)(A). This requirement in §19.2017(b) should result in greater efficiency and less required time for the URA and in a quicker response time for the injured employee or enrollee who is requesting the independent review. TDI clarifies that the provision implements Insurance Code §4201.402.

Comment: A commenter submits that the deadline to respond in regard to life-threatening conditions in §19.2017(b) should be a matter of hours, not a matter of days, noting that other provisions have shorter deadlines and that this provision should as well.

Agency Response: TDI declines to reduce the deadline for a URA to notify TDI because the URA needs time to gather all of the required documentation that needs to be submitted with the IRO request. TDI expects that all parties will expedite life-threatening cases.

Comment: A commenter asserts that §19.2017(b) is inappropriate for the workers' compensation rules and should be deleted in its entirety including its subparts.

Agency Response: TDI declines to make the suggested deletion. See TDI's response to §19.2011(a)(9). TDI clarifies that the provision implements Insurance Code §4201.402. This notification requirement should result in faster processing time, efficiency for the URA, and in a quicker response time for the injured employee or enrollee who is requesting the independent review.

Comment: A commenter notes that, just as in the comments to proposed §19.2011(a)(9), §19.2017 has no applicability to the workers' compensation context. The Workers' Compensation Act already provides that health care provided in medical emergencies is not subject to prospective review under Labor Code §413.014. A URA may perform utilization review for medical emergency services only on a retrospective basis. Expedited review and special independent review organization procedures are not necessary for a retrospective review determination. The commenter asserts that proposed §19.2017 should be withdrawn.

Agency Response: TDI declines to make the suggested deletion. See TDI's response to §19.2011(a)(9).

§19.1718. Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans.

Comment: A commenter asks for clarification of when the three calendar days in §19.1718 versus the three working days of §19.1709 is applicable because the requirement to allow one business day for a peer-to-peer discussion may conflict with the three calendar day timeframe.

Agency Response: TDI clarifies that an HMO or preferred provider benefit plan must issue and transmit a determination for proposed medical or health care services for concurrent hospitalization care within 24 hours of receipt of the request. An HMO or preferred provider benefit plan must issue and transmit a determination for proposed medical care or health care services involving post-stabilization treatment within one hour from receipt of the request.

URAs must issue a determination for requests for prospective review no later than the third working day. This three-working day timeframe is compatible with the requirement that the provider of record be afforded no less than one working day to discuss the determination. However, for concurrent review, TDI recognizes that requiring one working day for the peer-to-peer discussion may prevent the URA from providing the determination within the required 24-hour timeframes. Additionally, for post-stabilization treatment requests, TDI recognizes that requiring one working day for the peer-to-peer discussion may prevent the URA from providing the determination within the required one-hour timeframes. The adopted rules provide that a reasonable opportunity means at least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination: (A) no less than one working day prior to issuing a prospective utilization review adverse determination; (B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or (C) prior to issuing a concurrent or post-stabilization review adverse determination.

NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For: Office of Public Insurance Counsel.

For, with recommended changes: Scott and White Health Plan, Texas Medical Board, and Texas Mutual Insurance Company.

Neither for nor against, with recommended changes: American Insurance Association, Center for Public Policy Priorities, Forte, MedConfirm, Office of Injured Employee Counsel, Review Med, State Office of Risk Management, Texas Association of Health Plans, Texas Association of School Boards, Texas Medical Association, Unimed Direct, and two individuals.

Against, with recommended changes: Insurance Council of Texas, Property Casualty Insurers Association of America, and PRIUM.

SUBCHAPTER R. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER A HEALTH BENEFIT PLAN OR HEALTH INSURANCE POLICY

28 TAC §§19.1701 - 19.1719

STATUTORY AUTHORITY. The new sections are adopted under Insurance Code Chapter 4201 (Utilization Review Agents), §38.001 (Data Collection and Reports: Inquiries), §843.151 (Regulation of Health Maintenance Organizations: Rules), §1301.007 (Preferred Provider Benefit Plans: Rules), §1305.007 (Workers' Compensation Health Care Networks: Rules), §1352.003(g) (Brain Injury: Required Coverages-Health Benefit Plans Other than Small Employer Health Benefit Plans), §1352.004(b) (Brain Injury: Training for Certain Personnel Required), §1369.057 (Benefits Related to Prescription Drugs and Devices and Related Services: Rules), and Insurance Code §36.001 (Department Rules and Procedures: General Rulemaking Authority).

Additionally, the new sections are adopted under Labor Code §401.011 (Definitions: General Definitions); Chapter 402 (Operation and Administration of Workers' Compensation System), including §§402.00111(b) (Relationship between Commissioner of Insurance and Commissioner of Workers' Compensation; Separation of Authority; Rulemaking), 402.00116 (Chief Executive), 402.00128 (General Powers and Duties of Commissioner), and 402.061 (Adoption of Rules); Chapter 408 (Workers' Compensation Benefits), including §§408.0043 (Professional Specialty Certification Required for Certain Review), 408.0044 (Review of Dental Services), 408.0045 (Review of Chiropractic Services), 408.0046 (Rules), 408.021 (Entitlement to Medical Benefits), 408.023 (List of Approved Doctors; Duties of Treating Doctors), and 408.0231 (Maintenance of List of Approved Doctors; Sanctions and Privileges Relating to Health Care); §412.0215 (Sanctions); Chapter 413 (Medical Review), including §§413.011 (Reimbursement Policies and Guidelines; Treatment Guidelines and Protocols), 413.014 (Preauthorization Requirements; Concurrent Review and Certification of Health Care), 413.015 (Payment by Insurance Carriers; Audit and Review), 413.017 (Presumption of Reasonableness), 413.031 (Medical Dispute Resolution), 413.0511 (Medical Advisor), 413.0512 (Medical Quality Review Panel), 413.0513 (Confidentiality Requirements), 413.052 (Production of Documents); and the Occupations Code §155.001 (License to Practice Medicine: Examination Required).

The purpose of Chapter 4201 is stated in Subchapter A §4201.001, which is to: (i) promote the delivery of quality health care in a cost-effective manner; (ii) ensure that a URA adheres to reasonable standards for conducting utilization review; (iii) foster greater coordination and cooperation between a health care provider and URA; (iv) improve communications and knowledge of benefits among all parties concerned before an expense is incurred; and (v) ensure that a URA maintains the confidentiality of medical records in accord with applicable law.

Insurance Code §4201.002 defines the various terms used in the chapter, among them "adverse determination" in §4201.002(1) and "utilization review" in §4201.002(13), which are incorporated into the adopted rules. Section 4201.003 provides that the commissioner of insurance may adopt rules to implement Insurance Code Chapter 4201. Section 4201.004 specifies the statutory requirements concerning telephone access to a URA.

Subchapter B (Applicability of Chapter) of Chapter 4201 addresses persons providing information about scope of coverage or benefits; certain contracts with the federal government; Medicaid and certain other state health or mental health programs; workers' compensation benefits; health care service provided under automobile insurance policies; employee welfare benefit plans; HMOs; and insurers. Regarding workers' compensation benefits, §4201.054(a) provides, in relevant part, "The commissioner of workers' compensation shall regulate as provided by this chapter a person who performs utilization review of a medical benefit provided under Title 5, Labor Code." Section 4201.054(c) also states, "Title 5, Labor Code, prevails in the event of a conflict between this chapter and Title 5, Labor Code." Section 4201.054(d) further provides, "The commissioner of workers' compensation may adopt rules as necessary to implement this section."

Subchapter C (Certification) specifies that a certification of registration is required to conduct utilization review, requirements for certification, certificate renewal, certification and renewal forms, fees, non-transferability of certificate, reporting material changes, and list of URAs. Section 4201.101 provides, "A utilization review agent may not conduct utilization review unless the commissioner issues a certificate of registration to the agent under this subchapter." Further, §4201.102(a) provides, "The commissioner may issue a certificate of registration only to an applicant who has met all the requirements of this chapter and all the applicable rules adopted by the commissioner."

Subchapter D (Utilization Review: General Standards) sets forth statutory standards regarding utilization review plans under §4201.151; the mandate under §4201.152 that a utilization review must be under the direction of a physician licensed to practice medicine by a state licensing agency in the United States; and the mandate under §4201.153 that screening criteria be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow a deviation from the norm when justified on a case-by-case basis. Section 4201.154 provides for review and inspection of screening criteria and review procedures. Section 4201.155 provides that a URA may not establish or impose a notice requirement or other review procedure that is contrary to the requirements of the health insurance policy or health benefit plan.

Subchapter E (Utilization Review: Relations with Patients and Health Care Providers) §§4201.201, 4201.202, 4201.203, 4201.204, 4201.205, 4201.206, and 4201.207 address utilization review relations with patients and health care providers, including repetitive contacts; frequency of reviews; observing or participating in patient's care; mental health therapy; complaint system of the URA; designated initial contact; and opportunity to discuss treatment before issuance of adverse determination.

Subchapter F (Utilization Review: Personnel) §§4201.251, 4201.252, and 4201.253 address personnel matters, including delegation of utilization review, appropriate training, qualification of employed or contracted personnel, and prohibited bases for employment, compensation, evaluation, or performance standards.

Subchapter G (Notice of Determinations) specifies the general duty to notify under §4201.301, the general time for notice under §4201.302, what the contents of the notice of an adverse determination must include under §4201.303, the timeframes for notice of adverse determination under §4201.304, and what the notice of adverse determination for retrospective utilization review must include under §4201.305.

Subchapter H (Appeal of Adverse Determination) specifies the procedure for appeal of an adverse determination, including a provision in §4201.351 that for purposes of Subchapter H, a complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination. Section 4201.352 requires a URA to maintain and make available a written description of the procedures for appealing an adverse determination, and §4201.353 mandates that these procedures be reasonable. Subchapter H further addresses requirements for persons or entities that may appeal in §4201.354, acknowledgement of appeal in §4201.355, specialty review procedures in §4201.356, expedited appeal for denial of emergency care or continued hospitalization in §4201.357, response letter to interested persons in §4201.358, written notice to the appealing party of the determination of the appeal as soon as practicable in §4201.359, and immediate appeal to an IRO in life-threatening circumstances in §4201.360.

Subchapter I (Independent Review of Adverse Determination) sets forth the statutory requirements for the independent review

of an adverse determination, addresses the review by the IRO and the URA's compliance with the independent determination in §4201.401, the information a URA must provide to the appropriate IRO in §4201.402, and payment for independent review in §4201.403.

Subchapter J (Specialty Utilization Review Agents) §4201.451 specifies definitions and requirements governing URAs that conduct utilization review for a specialty health care service, including dentistry, chiropractic services, or physical therapy.

Subchapter K (Claims Review of Medical Necessity and Appropriateness) of Chapter 4201 was repealed effective September 1, 2009.

Subchapter L (Confidentiality of Information; Access to Other Information) addresses general confidentiality requirements, consent requirements, providing information to affiliated entities, providing information to the commissioner of insurance, access to recorded personal information, publishing information identifiable to a health care provider, the requirement to maintain data in a confidential manner, and the destruction of certain confidential documents.

Subchapter M (Enforcement) concerns notice of suspected violation, compelling production of information, enforcement proceedings, and remedies and penalties for violation. Section 4201.602 authorizes the commissioner of insurance to initiate a proceeding under Subchapter M, which is a contested case for purposes of Government Code Chapter 2001. Under §4201.603, the commissioner of insurance may impose remedies and penalties for violations of Chapter 4201, including a sanction under Chapter 82, an issuance of a cease and desist order under Chapter 83, or an assessment of an administrative penalty under Chapter 84.

Insurance Code §38.001 provides, in relevant part, that TDI may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (i) the person's business condition; or (ii) any matter connected with the person's transactions that TDI considers necessary for the public good or for the proper discharge of TDI's duties.

Insurance Code §843.151 provides, in relevant part, that the commissioner of insurance may adopt reasonable rules as necessary and proper to implement Insurance Code Chapter 843.

Insurance Code §1301.007 requires, in relevant part, the commissioner of insurance to adopt rules as necessary to implement Insurance Code Chapter 1301.

Insurance Code §1305.007 provides that the commissioner of insurance may adopt rules as necessary to implement Insurance Code Chapter 1305.

Insurance Code §1352.003(g) requires the commissioner of insurance to adopt rules as necessary to implement Insurance Code Chapter 1352.

Insurance Code §1352.004(b) requires the commissioner of insurance by rule to require a health benefit plan issuer to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan.

Insurance Code §1369.057 provides that the commissioner of insurance may adopt rules to implement Insurance Code Chapter 1369, Subchapter B (Coverage of Prescription Drugs Specified by Drug Formulary).

Insurance Code §36.001 provides that the commissioner of insurance may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

Labor Code §401.011 specifies definitions used in the Texas Workers' Compensation Act. In particular, §401.011(17) defines the term "doctor"; §401.011(19) defines the term "health care," which includes a prescription drug, medicine, or other remedy under §401.011(19)(E); §401.011(20) defines "health care facility"; and §401.011(22-a) defines the terminology "health care reasonably required." Section 401.011(27) defines the term "insurance carrier"; §401.011(28) defines "insurance company"; and §401.011(44) defines "workers' compensation insurance coverage."

Labor Code §402.00111(b) provides that the commissioner of insurance may delegate to the commissioner of workers' compensation or to that person's designee and may redact any delegation, and the commissioner of workers' compensation may delegate to the commissioner of insurance or to that person's designee, any power or duty regarding workers' compensation imposed on the commissioner of insurance or the commissioner of workers' compensation under Labor Code Title 5, including the authority to make final orders or decisions. The delegation must be made in writing.

Labor Code §402.00116 grants the powers and duties of chief executive and administrative officer to the commissioner of workers' compensation and the authority to administer and enforce Labor Code Title 5, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to TDI-DWC or the commissioner of workers' compensation.

Labor Code §402.00128 vests general operational powers in the commissioner of workers' compensation to conduct daily operations of TDI-DWC and implement policy, including the authority to delegate, assess, and enforce penalties and enter appropriate orders as authorized by Labor Code Title 5.

Labor Code §402.061 grants the commissioner of workers' compensation the authority to adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act.

Labor Code §412.0215(a) provides that TDI-DWC may impose sanctions against any person regulated by TDI-DWC.

Labor Code §408.0043(a) applies to a person, other than a chiropractor or dentist, who performs health care services under Labor Code Title 5, as a doctor performing peer reviews, utilization reviews, independent reviews, required medical examinations, or who serves on the medical quality review panel or as a designated doctor for TDI-DWC. Labor Code §408.0043(b) requires that a person described by Labor Code §408.0043(a), who reviews a specific workers' compensation case, hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving.

Labor Code §408.0044 pertains to dentists who perform dental services under Labor Code Title 5 for peer reviews, utilization reviews, independent reviews, or required dental examinations. Labor Code §408.0044(b) requires that a dentist who reviews a dental service in conjunction with a specific workers' compensation case be licensed to practice dentistry.

Labor Code §408.0045 pertains to chiropractors who perform chiropractic services under Labor Code Title 5 for peer reviews, utilization reviews, independent reviews, required medical ex-

aminations, or who serve on the medical quality review panel or as designated doctors providing chiropractic services for TDI-DWC. Labor Code §408.0045(b) requires that a chiropractor who reviews a chiropractic service in conjunction with a specific workers' compensation case be licensed to engage in the practice of chiropractic services.

Labor Code §408.0046 authorizes the commissioner of workers' compensation to adopt rules as necessary to determine which professional health practitioner specialties are appropriate for treatment of certain compensable injuries, and the rules must require an entity requesting a peer review to obtain and provide to the doctor providing the peer review services all relevant and updated medical records. Labor Code §408.021(a) specifies that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed.

Labor Code §408.023(h) requires that a URA or an insurance carrier that uses doctors to perform reviews of health care services provided under Labor Code Title 5, Subtitle A, including utilization review, only use doctors licensed to practice in this state. Section 408.023(n) requires the commissioner of workers' compensation to adopt rules to establish reasonable requirements for doctors and health care providers financially related to those doctors, including training, impairment rating testing, financial disclosure, and monitoring.

Labor Code §408.0231(g) requires the commissioner of workers' compensation to adopt rules regarding doctors who perform peer review functions for insurance carriers. Those rules may include standards for peer review; imposition of sanctions on doctors performing peer review functions, including restriction, suspension, or removal of the doctor's ability to perform peer review on behalf of insurance carriers in the workers' compensation system; and other issues important to the quality of peer review, as determined by the commissioner.

Labor Code §413.011 requires the commissioner of workers' compensation by rule to establish medical policies and guidelines relating to necessary treatment for injuries designed to ensure the quality of medical care and achieve effective medical cost control.

Labor Code §413.014 requires preauthorization by insurance carriers for specified health care treatments and services. Section 413.014(a) defines the terminology "investigational or experimental service or device."

Labor Code §413.015 requires insurance carriers to pay for medical services as provided in the statute and requires that TDI-DWC ensure compliance with the medical policies and fee guidelines through audit and review.

Labor Code §413.017 provides a presumption of reasonableness for medical services consistent with TDI-DWC medical policies and fee guidelines and medical services that are provided subject to prospective, concurrent, or retrospective review as required by TDI-DWC policies and authorized by the insurance carrier.

Labor Code §413.031(d) provides that a review of the medical necessity of a health care service requiring preauthorization under §413.014 or commissioner of workers' compensation rules promulgated under §413.014 or §413.011(g) be conducted by an IRO under Insurance Code Chapter 4202 in the same manner as reviews of utilization review decisions by HMOs.

Labor Code §413.0511(b) provides that the TDI-DWC medical advisor shall make recommendations regarding the adoption of rules and policies relating to medical benefits as required by the commissioner of workers' compensation.

Labor Code §413.0512(a) requires the TDI-DWC medical advisor to establish a medical quality review panel of health care providers to assist the medical advisor in performing the required duties under §413.0511.

Labor Code §413.0513(a) provides that information collected, assembled, or maintained by or on behalf of TDI-DWC under §413.0511 or §413.0512 constitutes an investigation file and may not be disclosed.

Labor Code §413.052 provides that the commissioner of workers' compensation by rule shall establish procedures to enable TDI-DWC to compel the production of documents.

Labor Code §504.053(b)(2) provides that if a political subdivision or a pool determines that a workers' compensation health care network certified under Insurance Code Chapter 1305 is not available or practical for the political subdivision or pool, the political subdivision or pool may provide medical benefits to its injured employees or to the injured employees of the members of the pool by directly contracting with health care providers or by contracting through a health benefits pool established under Local Government Code Chapter 172.

Labor Code §504.055(b) provides that §504.055 applies only to a first responder who sustains a serious bodily injury, as defined by Penal Code §1.07, in the course and scope of employment.

Labor Code §504.055(c), states that, "The political subdivision, division, and insurance carrier shall accelerate and give priority to an injured first responder's claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury described by Subsection (b)."

Labor Code §504.056 provides that the purpose of Labor Code §504.055 is to ensure that an injured first responder's claim for medical benefits is accelerated by a political subdivision, insurance carrier, and the division to the full extent authorized by current law.

The Occupations Code §155.001 provides that a person may not practice medicine in this state unless the person holds a license issued under Occupations Code, Title 3, Subtitle B.

§19.1701. General Provisions.

(a) Statutory basis. This subchapter implements Insurance Code Chapter 4201, concerning Utilization Review Agents.

(b) Severability. If a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are severable.

(c) Purpose. The purpose of this subchapter is to:

(1) promote the delivery of quality health care in a cost-effective manner, including protection of enrollee safety;

(2) ensure that URAs adhere to reasonable standards for conducting utilization reviews;

(3) foster greater coordination and cooperation between health care providers and URAs;

(4) improve communications and knowledge of medical benefits among all parties concerned before expenses are incurred; and

(5) ensure that URAs maintain the confidentiality of medical records in accord with applicable law.

§19.1702. Applicability.

(a) Limitations on applicability. Except as provided in Insurance Code Chapter 4201, this subchapter applies to utilization review performed under a health benefit plan or a health insurance policy.

(1) This subchapter does not apply to utilization review performed under workers' compensation insurance coverage.

(2) This subchapter does not apply to a person who provides information to an enrollee; an individual acting on behalf of an enrollee; or an enrollee's physician, doctor, or other health care provider about scope of coverage or benefits, and does not determine medical necessity or appropriateness or the experimental or investigational nature of health care services.

(b) Applicability of other law. In addition to the requirements of this subchapter, provisions of Insurance Code Chapter 843, concerning Health Maintenance Organizations; Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans; Insurance Code Chapter 1352, concerning Brain Injury; and Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services, apply to this subchapter.

§19.1703. Definitions.

(a) The words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in this subchapter, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Adverse determination--A determination by a URA made on behalf of any payor that the health care services provided or proposed to be provided to an enrollee are not medically necessary or appropriate or are experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

(2) Appeal--A URA's formal process by which an enrollee, an individual acting on behalf of an enrollee, or an enrollee's provider of record may request reconsideration of an adverse determination.

(3) Biographical affidavit--National Association of Insurance Commissioners biographical affidavit to be used as an attachment to the URA application.

(4) Certificate--A certificate issued by the commissioner to an entity authorizing the entity to operate as a URA in the State of Texas. A certificate is not issued to an insurance carrier or health maintenance organization that is registered as a URA under §19.1704 of this title (relating to Certification or Registration of URAs).

(5) Commissioner--As defined in Insurance Code §31.001.

(6) Complaint--An oral or written expression of dissatisfaction with a URA concerning the URA's process in conducting a utilization review. The term "complaint" does not include:

(A) an expression of dissatisfaction constituting an appeal under Insurance Code §4201.351; or

(B) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to the satisfaction of the complaining party.

(7) Concurrent utilization review--A form of utilization review for ongoing health care or for an extension of treatment beyond previously approved health care.

(8) Declination--A response to a request for verification in which an HMO or preferred provider benefit plan does not issue a verification for proposed medical care or health care services. A declination is not necessarily a determination that a claim resulting from the proposed services will not ultimately be paid.

(9) Disqualifying association--Any association that may reasonably be perceived as having potential to influence the conduct or decision of a reviewing physician, doctor, or other health care provider, which may include:

(A) shared investment or ownership interest;

(B) contracts or agreements that provide incentives, for example, referral fees, payments based on volume or value, or waiver of beneficiary coinsurance and deductible amounts;

(C) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, warranties, or any other services related to the management of a physician's, doctor's, or other health care provider's practice;

(D) personal or family relationships; or

(E) any other financial arrangement that would require disclosure under the Insurance Code or applicable TDI rules, or any other association with the enrollee, employer, insurance carrier, or HMO that may give the appearance of preventing the reviewing physician, doctor, or other health care provider from rendering an unbiased opinion.

(10) Doctor--A doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.

(11) Experimental or investigational--A health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device, but that is not yet broadly accepted as the prevailing standard of care.

(12) Health care facility--A hospital, emergency clinic, outpatient clinic, or other facility providing health care.

(13) Health coverage--Payment for health care services provided under a health benefit plan or a health insurance policy.

(14) Health maintenance organization or HMO--As defined in Insurance Code §843.002.

(15) Insurance carrier or insurer--An entity authorized and admitted to do the business of insurance in Texas under a certificate of authority issued by TDI.

(16) Independent review organization or IRO--As defined in §12.5 of this title (relating to Definitions).

(17) Legal holiday--

(A) a holiday as provided in Government Code §662.003(a);

(B) the Friday after Thanksgiving Day;

(C) December 24; and

(D) December 26.

(18) Medical records--The history of diagnosis and treatment, including medical, mental health records as allowed by law, dental, and other health care records from all disciplines providing care to an enrollee.

(19) Mental health medical record summary--A summary of process or progress notes relevant to understanding the enrollee's need for treatment of a mental or emotional condition or disorder, including:

(A) identifying information; and

(B) a treatment plan that includes a:

(i) diagnosis;

(ii) treatment intervention;

(iii) general characterization of enrollee behaviors or thought processes that affect level of care needs; and

(iv) discharge plan.

(20) Mental health therapist--Any of the following individuals who, in the ordinary course of business or professional practice, as appropriate, diagnose, evaluate, or treat any mental or emotional condition or disorder:

(A) an individual licensed by the Texas Medical Board to practice medicine in this state;

(B) an individual licensed as a psychologist, a psychological associate, or a specialist in school psychology by the Texas State Board of Examiners of Psychologists;

(C) an individual licensed as a marriage and family therapist by the Texas State Board of Examiners of Marriage and Family Therapists;

(D) an individual licensed as a professional counselor by the Texas State Board of Examiners of Professional Counselors;

(E) an individual licensed as a social worker by the Texas State Board of Social Worker Examiners;

(F) an individual licensed as a physician assistant by the Texas Medical Board;

(G) an individual licensed as a registered professional nurse by the Texas Board of Nursing; or

(H) any other individual who is licensed or certified by a state licensing board in the State of Texas, as appropriate, to diagnose, evaluate, or treat any mental or emotional condition or disorder.

(21) Mental or emotional condition or disorder--A mental or emotional illness as detailed in the most current Diagnostic and Statistical Manual of Mental Disorders.

(22) Person--Any individual, partnership, association, corporation, organization, trust, hospital district, community mental health center, mental retardation center, mental health and mental retardation center, limited liability company, limited liability partnership, the statewide rural health care system under Insurance Code Chapter 845, and any similar entity.

(23) Preauthorization--A form of prospective utilization review by a payor or its URA of health care services proposed to be provided to an enrollee.

(24) Preferred provider--

(A) with regard to a preferred provider benefit plan, a preferred provider as defined in Insurance Code Chapter 1301.

(B) with regard to an HMO:

(i) a physician, as defined in Insurance Code §843.002(22), who is a member of that HMO's delivery network; or

(ii) a provider, as defined in Insurance Code §843.002(24), who is a member of that HMO's delivery network.

(25) Provider of record--The physician, doctor, or other health care provider that has primary responsibility for the health care services rendered or requested on behalf of the enrollee or the physician, doctor, or other health care provider that has rendered or has been requested to provide the health care services to the enrollee. This definition includes any health care facility where health care services are rendered on an inpatient or outpatient basis.

(26) Reasonable opportunity--At least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day prior to issuing a prospective utilization review adverse determination;

(B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or

(C) prior to issuing a concurrent or post-stabilization review adverse determination.

(27) Registration--The process for a licensed insurance carrier or HMO to register with TDI to perform utilization review solely for its own enrollees.

(28) Request for a review by an IRO--Form to request a review by an independent review organization that is completed by the requesting party and submitted to the URA.

(29) Retrospective utilization review--A form of utilization review for health care services that have been provided to an enrollee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

(30) Routine vision services--A routine annual or biennial eye examination to determine ocular health and refractive conditions that may include provision of glasses or contact lenses.

(31) Screening criteria--The written policies, decision rules, medical protocols, or treatment guidelines used by the URA as part of the utilization review process.

(32) TDI--The Texas Department of Insurance.

(33) URA--Utilization review agent.

(34) URA application--Form for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state.

(35) Verification--A guarantee by an HMO or preferred provider benefit plan that the HMO or preferred provider benefit plan will pay for proposed medical care or health care services if the services are rendered within the required timeframe to the enrollee for whom the services are proposed. The term includes pre-certification, certification, re-certification, and any other term that would be a reliable representation by an HMO or preferred provider benefit plan to a physician or provider if the request for the pre-certification, certification, re-certification, or representation includes the requirements of

§19.1719 of this title (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans).

§19.1704. Certification or Registration of URAs.

(a) Applicability of certification or registration requirements. A person acting as or holding itself out as a URA under this subchapter must be certified or registered, as applicable, under Insurance Code §§4201.057, 4201.058, 4201.101, and this subchapter.

(1) If an insurance carrier or HMO performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, the insurance carrier or HMO must be certified.

(2) If an insurance carrier or HMO performs utilization review only for coverage for which it is the payor, the insurance carrier or HMO must be registered.

(b) Application form. The commissioner adopts by reference the:

(1) URA application, for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state; and

(2) Biographical affidavit, to be used as an attachment to the URA application.

(c) Original application fee. The original application fee specified in §19.802 of this title (relating to Amount of Fees) must be sent to TDI with the application for certification. A person applying for registration is not required to pay a fee.

(d) Where to obtain and send the URA application form. Forms may be obtained from www.tdi.texas.gov/forms and must be sent to: Texas Department of Insurance, Managed Care Quality Assurance Office, Mail Code 103-6A, P.O. Box 149104, Austin, Texas 78714-9104.

(e) Original application process. Within 60 calendar days after receipt of a complete application, TDI will process the application and issue or deny a certification or registration. TDI will send a certificate or a letter of registration to an entity that is granted certification or registration. The applicant may waive the time limit described in this subsection.

(f) Omissions or deficiencies. TDI will send the applicant written notice of any omissions or deficiencies in the application. The applicant must correct the omissions or deficiencies in the application or request additional time in writing within 15 working days of the date of TDI's latest notice of the omissions or deficiencies. If the applicant fails to do so, the application will not be processed and the file will be closed as an incomplete application. The application fee is not refundable. The request for additional time must be approved by TDI in writing to be effective.

(g) Certification and registration expiration. Each URA registration or certification issued by TDI and not suspended or revoked by the commissioner expires on the second anniversary of the date of issuance.

(h) Renewal requirements. A URA must apply for renewal of certification or registration every two years from the date of issuance by submitting the URA application form to TDI. The URA must also submit a renewal fee in the amount specified by §19.802(b)(19) of this title for renewal of a certification. A person applying for renewal of a registration is not required to pay a fee.

(1) Continued operation during review. If a URA submits the required information and fees specified in this subsection on or before the expiration of the certification or registration, the URA may continue to operate under its certification or registration until the renewal certification or registration is denied or issued.

(2) Expiration for 90 calendar days or less. If the certification or registration has been expired for 90 calendar days or less, a URA may renew the certification or registration by sending a completed renewal application and fee, as applicable. The URA may not operate from the time the certification or registration has expired until the time TDI has issued a renewal certification or registration.

(3) Expiration for longer than 90 calendar days. If a URA's certification or registration has been expired for longer than 90 calendar days, the URA may not renew the certification or registration. The URA must obtain a new certification or registration by submitting an application for original issuance of the certification or registration and an original application fee as applicable.

(i) Contesting a denial. If an application for an original or renewal certification or registration is denied, the applicant may contest the denial under the provisions of Chapter 1, Subchapter A, of this title (relating to Rules of Practice and Procedure) and Government Code Chapter 2001, concerning Administrative Procedure.

(j) Updating information on effective date. A URA that is certified or registered before the effective date of this rule must submit an updated application to TDI to comply with this subchapter within 90 calendar days after the effective date of this rule. However, the submission of an updated application does not change the URA's existing renewal date, and this section still governs the URA's renewal process.

§19.1705. General Standards of Utilization Review.

(a) Review of utilization review plan. The utilization review plan must be reviewed and approved by a physician and conducted under standards developed and periodically updated with input from both primary and specialty physicians, doctors, and other health care providers, as appropriate.

(b) Special circumstances. A utilization review determination must be made in a manner that takes special circumstances of the case into account that may require deviation from the norm stated in the screening criteria or relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness.

(c) Screening criteria. Each URA must utilize written screening criteria that are evidence-based, scientifically valid, outcome-focused, and that comply with the requirements in Insurance Code §4201.153. The screening criteria must also recognize that if evidence-based medicine is not available for a particular health care service provided, the URA must utilize generally accepted standards of medical practice recognized in the medical community.

(d) Referral and determination of adverse determinations. Adverse determinations must be referred to and may only be determined by an appropriate physician, doctor, or other health care provider with appropriate credentials under §19.1706 of this title (relating to Requirements and Prohibitions Relating to Personnel) to determine medical necessity or appropriateness, or the experimental or investigational nature, of health care services.

(e) Delegation of review. A URA, including a specialty URA, may delegate the utilization review to qualified personnel in a hospital or other health care facility in which the health care services to be reviewed were, or are, to be provided. The delegation does not relieve the URA of full responsibility for compliance with this subchapter and Insurance Code Chapter 4201, including the conduct of those to whom utilization review has been delegated.

(f) Complaint system. The URA must develop and implement procedures for the resolution of oral or written complaints initiated by enrollees, individuals acting on behalf of the enrollee, or health care providers concerning the utilization review. The URA must maintain records of complaints for three years from the date the complaints are filed. The complaints procedure must include a requirement for a written response to the complainant by the agent within 30 calendar days. The written response must include TDI's address, toll-free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI.

§19.1706. Requirements and Prohibitions Relating to Personnel.

(a) Qualification requirements. Physicians, doctors, and other health care providers employed by or under contract with a URA to perform utilization review must be appropriately trained, qualified, and currently licensed. Personnel conducting utilization review must hold an unrestricted license, an administrative license, or be otherwise authorized to provide health care services by a licensing agency in the United States.

(1) This subchapter does not supersede requirements in the Medical Practice Act; Texas Medical Board rules; Texas Occupations Code Chapter 201 (relating to Chiropractors); or Texas Board of Chiropractic Examiners rules. Individuals licensed by the Texas Medical Board are subject to 22 TAC Chapter 190, regarding disciplinary guidelines.

(2) Personnel who perform clerical or administrative tasks are not required to have the qualifications prescribed by this subsection.

(b) Disqualifying associations. For purposes of this subsection, being employed by or under contract with the same URA as the physician, doctor, or other health care provider who issued the initial adverse determination does not in itself constitute a disqualifying association. A physician, doctor, or health care provider who conducts utilization review must not have any disqualifying associations with the:

(1) enrollee or health care provider who is requesting the utilization review or an appeal; or

(2) physician, doctor, or other health care provider who issued the initial adverse determination.

(c) Information to be sent to TDI. The URA must send to TDI the name, type, license number, state of licensure, and qualifications of the personnel either employed or under contract to perform the utilization review with an original or renewal application.

(d) Written procedures and maintenance of records. URAs must develop and implement written procedures and maintain documentation to demonstrate that all physicians, doctors, and other health care providers used by the URA are licensed, qualified, and appropriately trained or experienced.

(e) Training related to acquired brain injury treatment. A URA must provide adequate training to personnel responsible for precertification, certification, and recertification of services or treatment relating to acquired brain injury in accord with Insurance Code §1352.004. The purpose of the training is to prevent denial of coverage in violation of Insurance Code §1352.003 and to avoid confusion of medical benefits with mental health benefits.

§19.1707. URA Contact with and Receipt of Information from Health Care Providers.

(a) If a URA must reimburse health care providers for providing medical information under Insurance Code §4201.207, reimbursement is limited to the reasonable costs for providing medical records relevant to the utilization review that were requested by the URA in writing. A health care provider's charge for providing medical information to a URA must comply with §134.120 of this title (relating to Reimbursement for Medical Documentation) and may not include any costs that are recouped as a part of the charge for health care.

(b) When conducting routine utilization review, the URA must request all relevant and updated information and medical records to complete the review.

(1) This information may include identifying information about the enrollee; the benefit plan or claim; the treating physician, doctor, or other health care provider; and the facilities rendering care. It may also include clinical and diagnostic testing information regarding the diagnoses of the enrollee and the medical history of the enrollee relevant to the diagnoses; the enrollee's prognosis; and the plan of treatment prescribed by the provider of record, along with the provider of record's justification for the plan of treatment. The required information should be obtained from the appropriate source.

(2) URAs must not routinely request copies of all medical records on enrollees reviewed. During utilization review, copies of the necessary or pertinent sections of medical records should only be required when a difficulty develops in determining whether the health care is medically necessary or appropriate, or experimental or investigational.

(c) The URA must share among its various divisions all clinical and demographic information on individual enrollees to avoid duplicate requests for information from enrollees, physicians, doctors, and other health care providers.

(d) A URA may not require as a condition of approval of a health care service, or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes that relate to the mental health therapist's treatment of an enrollee's mental or emotional condition or disorder. This prohibition extends to requiring an oral, electronic, facsimile, or written submission or rendition of a mental health therapist's process or progress notes. This prohibition does not preclude the URA from requiring submission of:

(1) an enrollee's mental health medical record summary; or

(2) medical records or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder.

§19.1708. On-Site Review by a URA.

(a) Identification of URAs. If a URA's staff member is conducting an on-site or off-site review, each staff member must provide his or her name, the name of his or her organization, photo identification, and the URA identification card with the certification or registration number assigned by TDI when requested by an individual, including an enrollee or health care provider.

(b) On-site review. For on-site review conducted at a health care facility, URAs:

(1) must ensure that their on-site review staff:

(A) register with the appropriate contact individual, if available, prior to requesting any clinical information or assistance from health care facility staff; and

(B) wear appropriate health care facility supplied identification tags while on the health care facility premises;

(2) must agree, if so requested, that the medical records remain available in the designated areas during the on-site review and

that reasonable health care facility administrative procedures will be followed by on-site review staff to avoid disrupting health care facility operations or enrollee care. The procedures, however, should not obstruct or limit the ability of the URA to efficiently conduct the necessary review.

§19.1709. Notice of Determinations Made in Utilization Review.

(a) Notice requirements. A URA must send written notification to the enrollee or an individual acting on behalf of the enrollee and the enrollee's provider of record, including the health care provider who rendered the service, of a determination made in a utilization review.

(b) Required notice elements. In all instances of a prospective, concurrent, or retrospective utilization review adverse determination, written notification of the adverse determination by the URA must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description or the source of the screening criteria that were utilized as guidelines in making the determination;

(4) the professional specialty of the physician, doctor, or other health care provider that made the adverse determination;

(5) a description of the procedure for the URA's complaint system as required by §19.1705 of this title (relating to General Standards of Utilization Review);

(6) a description of the URA's appeal process, as required by §19.1711 of this title (relating to Written Procedures for Appeal of Adverse Determination);

(7) a copy of the request for a review by an IRO form, available at www.tdi.texas.gov/forms;

(8) notice of the independent review process with instructions that:

(A) request for a review by an IRO form must be completed by the enrollee, an individual acting on behalf of the enrollee, or the enrollee's provider of record and be returned to the insurance carrier or URA that made the adverse determination to begin the independent review process; and

(B) the release of medical information to the IRO, which is included as part of the independent review request for a review by an IRO form, must be signed by the enrollee or the enrollee's legal guardian; and

(9) a description of the enrollee's right to an immediate review by an IRO and of the procedures to obtain that review for an enrollee who has a life-threatening condition.

(c) Determination concerning an acquired brain injury. In addition to the notification required by this section, a URA must comply with this subsection in regard to a determination concerning an acquired brain injury as defined by §21.3102 of this title (relating to Definitions). Not later than three business days after the date an individual requests utilization review or requests an extension of coverage based on medical necessity or appropriateness, a URA must provide notification of the determination through a direct telephone contact to the individual making the request. This subsection does not apply to a determination made for coverage under a small employer health benefit plan.

(d) Prospective and concurrent review.

(1) Favorable determinations. The written notification of a favorable determination made in utilization review must be mailed or electronically transmitted as required by Insurance Code §4201.302.

(2) Preauthorization numbers. A URA must ensure that preauthorization numbers assigned by the URA comply with the data and format requirements contained in the standards adopted by the U.S. Department of Health and Human Services in 45 C.F.R. §162.1102, (relating to Standards for Health Care Claims or Equivalent Encounter Information Transaction), based on the type of service in the preauthorization request.

(3) Required timeframes. Except as otherwise provided by the Insurance Code, the timeframes for notification of the adverse determination begin from the date of the request and must comply with Insurance Code §4201.304. A URA must provide the notice to the provider of record or other health care provider not later than one hour after the time of the request when denying post-stabilization care subsequent to emergency treatment as requested by a provider of record or other health care provider. The URA must send written notification within three working days of the telephone or electronic transmission.

(e) Retrospective review.

(1) The URA must develop and implement written procedures for providing the notice of adverse determination for retrospective utilization review, including the timeframes for the notice of adverse determination, that comply with Insurance Code §4201.305 and this section.

(2) When a retrospective review of the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services is made in relation to health coverage, the URA may not require the submission or review of a mental health therapist's process or progress notes that relate to the mental health therapist's treatment of an enrollee's mental or emotional condition or disorder. This prohibition extends to requiring an oral, electronic, facsimile, or written submission or rendition of a mental health therapist's process or progress notes. This prohibition does not preclude requiring submission of:

(A) an enrollee's mental health medical record summary; or

(B) medical records or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder.

§19.1711. Written Procedures for Appeal of Adverse Determinations.

(a) Appeal of prospective or concurrent review adverse determinations. Each URA must comply with its written procedures for appeals. The written procedures for appeals must comply with Insurance Code Chapter 4201, Subchapter H, concerning Appeal of Adverse Determination, and must include provisions that specify the following:

(1) timeframes for filing the written or oral appeal, which may not be less than 30 calendar days after the date of issuance of written notification of an adverse determination;

(2) an enrollee, an individual acting on behalf of the enrollee, or the provider of record may appeal the adverse determination orally or in writing;

(3) an appeal acknowledgement letter must:

(A) be sent to the appealing party within five working days from receipt of the appeal;

(B) acknowledge the date the URA received the appeal;

(C) include a list of relevant documents that must be submitted by the appealing party to the URA; and

(D) include a one-page appeal form to be filled out by the appealing party when the URA receives an oral appeal of an adverse determination.

(4) Appeal decisions must be made by a physician who has not previously reviewed the case.

(5) In any instance in which the URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician. The provision must require that the discussion include, at a minimum, the clinical basis for the URA's decision.

(6) If an appeal is denied and, within 10 working days from the denial, the health care provider sets forth in writing good cause for having a particular type of specialty provider review the case, the denial must be reviewed by a health care provider in the same or similar specialty that typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review of the adverse determination. The specialty review must be completed within 15 working days of receipt of the request. The provision must state that notification of the appeal under this paragraph must be in writing.

(7) In addition to the written appeal, a method for expedited appeals for emergency care denials, denials of care for life-threatening conditions, and denials of continued stays for hospitalized enrollees is available. The provision must state that:

(A) the procedure must include a review by a health care provider who has not previously reviewed the case and who is of the same or a similar specialty as the health care provider that typically manages the medical condition, procedure, or treatment under review;

(B) an expedited appeal must be completed based on the immediacy of the medical or dental condition, procedure, or treatment, but may in no event exceed one working day from the date all information necessary to complete the appeal is received; and

(C) an expedited appeal determination may be provided by telephone or electronic transmission, but must be followed with a letter within three working days of the initial telephonic or electronic notification;

(8) After the URA has sought review of the appeal of the adverse determination, the URA must issue a response letter to the enrollee or an individual acting on behalf of the enrollee, and the provider of record, explaining the resolution of the appeal. The provision must state that the letter must include:

(A) a statement of the specific medical, dental, or contractual reasons for the resolution;

(B) the clinical basis for the decision;

(C) a description of or the source of the screening criteria that were utilized in making the determination;

(D) the professional specialty of the physician who made the determination;

(E) notice of the appealing party's right to seek review of the adverse determination by an IRO under §19.1717 of this title (relating to Independent Review of Adverse Determinations);

(F) notice of the independent review process;

(G) a copy of a request for a review by an IRO form; and

(H) procedures for filing a complaint as described in §19.1705(f) of this title (relating to General Standards of Utilization Review).

(9) A statement that the appeal must be resolved as soon as practical, but, under Insurance Code §4201.359 and §1352.006, in no case later than 30 calendar days after the date the URA receives the appeal from the appealing party referenced under paragraph (3) of this subsection.

(10) In a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an IRO and is not required to comply with procedures for an appeal of the URA's adverse determination.

(b) Appeal of retrospective review adverse determinations. A URA must maintain and make available a written description of the appeal procedures involving an adverse determination in a retrospective review. The written procedures for appeals must specify that an enrollee, an individual acting on behalf of the enrollee, or the provider of record may appeal the adverse determination orally or in writing. The appeal procedures must comply with:

(1) Chapter 21, Subchapter T, of this title (relating to Submission of Clean Claims), if applicable;

(2) Section 19.1709 of this title (relating to Notice of Determinations Made in Utilization Review), for retrospective utilization review adverse determination appeals; and

(3) Insurance Code §4201.359.

(c) Appeals concerning an acquired brain injury. A URA must comply with this subsection in regard to a determination concerning an acquired brain injury as defined by §21.3102 of this title (relating to Definitions). Not later than three business days after the date on which an individual requests utilization review or requests an extension of coverage based on medical necessity or appropriateness, a URA must provide notification of the determination through a direct telephone contact to the individual making the request. This subsection does not apply to a determination made for coverage under a small employer health benefit plan.

§19.1713. Confidentiality.

(a) Confidentiality requirements. To ensure confidentiality, a URA must, when contacting a physician's, doctor's, or other health care provider's office, provide its certification number, name, and professional qualifications.

(1) If requested by the physician, doctor, or other health care provider, the URA must present written documentation that it is acting as an agent of the payor for the relevant enrollee.

(2) Medical records and enrollee specific information must be maintained by the URA in a secure area with access limited to essential personnel only.

(3) A URA must retain information generated and obtained by a URA in the course of utilization review for at least four years.

(4) A URA's charges for providing a copy of recorded personal information to individuals may not exceed 10 cents per page and may not include any costs that are otherwise recouped as part of the charge for utilization review.

(b) Written procedures on confidentiality.

(1) The URA must specify in writing the procedures that the URA will implement pertaining to confidentiality of information

received from the enrollee; the individual acting on behalf of the enrollee; and the physician, doctor, or other health care provider and the information exchanged between the URA and third parties for conducting utilization review. These procedures must specify that:

(A) specific information received from the enrollee; the individual acting on behalf of the enrollee; and the physician, doctor, or other health care provider and the information exchanged between the URA and third parties for conducting reviews will be considered confidential, be used by the review agent solely for utilization review, and be shared by the URA with only those third parties who have authority to receive the information, for example, the claim administrator; and

(B) the URA has procedures in place to address confidentiality and that the URA agrees to abide by any federal and state laws governing confidentiality.

(2) Summary data which does not provide sufficient information to allow identification of individual enrollees, physicians, doctors, or other health care providers is not considered confidential.

§19.1714. Regulatory Requirements Subsequent to Certification or Registration.

(a) Summary report to TDI. By March 1 of each year, each URA certified or registered under this subchapter must submit to TDI through TDI's internet website a complete summary report of information related to complaints, adverse determinations, and appeals of adverse determinations.

(b) Contents of summary report. The summary report required by this section must cover reviews performed by the URA during the preceding calendar year and must include:

(1) the total number of written notices of adverse determinations;

(2) a listing of appeals of adverse determinations, by the medical condition that is the source of the dispute using the approved physical diagnosis or DSM-IV (mental health diagnosis) coding that is in effect at the time, or successor codes and modifiers, and by the treatment in dispute, if any, using CPT (procedure) code or other relevant procedure code if a CPT designation is not available, or any other nationally recognized numerically codified diagnosis or procedure;

(3) the classification of appellant, for example, "health care provider" or "enrollee";

(4) the disposition of the appeal of adverse determination (either in favor of the appellant, or in favor of the original utilization review determination) at each level within the internal utilization review process; and

(5) the subject matter of any complaint filed with the URA.

(c) Complaints included in the summary report. Complaints listed in the summary report under subsection (b)(5) of this section must be categorized as follows:

(1) administration, for example, copies of medical records not paid for, too many calls or written requests for information from provider, or too much information requested from provider;

(2) qualifications of URA's personnel; or

(3) appeal or complaint process, for example, the treating physician is unable to discuss plan of treatment with utilization review physician, no notice of adverse determination, no notice of clinical basis for adverse determination, or written procedures for appeal not provided.

(d) Complaints to TDI. Complaints received by TDI against a URA must be processed under TDI's established procedures for investigation and resolution of complaints.

(e) TDI inquiries. TDI may address inquiries to a URA related to any matter connected with URA transactions that TDI considers necessary for the public good or for the proper discharge of TDI's duties. Under Insurance Code §38.001, a URA that receives an inquiry from TDI must respond to the inquiry in writing not later than the 10th day after the date the inquiry is received.

(f) On-site review by TDI. For scheduled and unscheduled on-site reviews, TDI may make a complete on-site review of the operations of each URA at the principal place of business for each agent as often as is deemed necessary. An on-site review will only be conducted during working days and normal business hours. The URA must make available all records relating to its operation during any scheduled and unscheduled on-site review.

(1) Scheduled on-site reviews. URAs will be notified of any scheduled on-site review by letter, which will specify, at a minimum, the identity of TDI's designated representative and the expected arrival date and time.

(2) Unscheduled on-site reviews. At a minimum, notice of an unscheduled on-site review of a URA will be in writing and be presented by TDI's designated representative on arrival.

§19.1717. Independent Review of Adverse Determinations.

(a) Notification for life-threatening conditions. For life-threatening conditions, notification of adverse determination by a URA must be provided within the timeframes specified in §19.1709(d)(3) of this title (relating to Notice of Determinations Made in Utilization Review).

(1) At the time of notification of the adverse determination, the URA must provide to the enrollee or individual acting on behalf of the enrollee, and to the enrollee's provider of record, the notice of the independent review process and a copy of the request for a review by an IRO form. The notice must describe how to obtain independent review of the adverse determination.

(2) The enrollee, individual acting on behalf of the enrollee, or the enrollee's provider of record must determine the existence of a life-threatening condition on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the enrollee's disease or condition is a life-threatening condition.

(b) Appeal of adverse determination involving life-threatening condition. Any party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination is denied by the URA may seek review of that determination or denial by an IRO assigned under Insurance Code Chapter 4202 and Chapter 12 of this title (relating to Independent Review Organizations).

(c) Independent review involving life-threatening and non life-threatening conditions. A URA, or insurance carrier that made the adverse determination, must notify TDI within one working day from the date the request for an independent review is received. The URA, or insurance carrier that made the adverse determination, must submit the completed request for a review by an IRO form to TDI through TDI's Internet website.

(1) Assignment of IRO. TDI will, within one working day of receipt of a complete request for independent review, randomly assign an IRO to conduct an independent review and notify the URA, payor, IRO, the enrollee or individual acting on behalf of the enrollee, enrollee's provider of record, and any other providers listed by the URA as having records relevant to the review of the assignment.

(2) Payor and URA compliance. The payor and URA must comply with the IRO's determination with respect to the medical necessity or appropriateness, or the experimental or investigational nature, of the health care items and services for an enrollee.

(3) Costs of independent review. The URA must pay for the independent review and may recover costs associated with the independent review from the payor.

§19.1718. Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans.

(a) The words and terms defined in Insurance Code Chapter 1301 and Chapter 843 have the same meaning when used in this section, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise.

(b) An HMO or preferred provider benefit plan that requires preauthorization as a condition of payment to a preferred provider must comply with the procedures of this section for determinations of medical necessity or appropriateness, or the experimental or investigational nature, of care for those services the HMO or preferred provider benefit plan identifies under subsection (c) of this section.

(c) An HMO or preferred provider benefit plan that uses a preauthorization process for medical care and health care services must provide to each contracted preferred provider, not later than the 10th working day after the date a request is made, a list of medical care and health care services that allows a preferred provider to determine which services require preauthorization and information concerning the preauthorization process.

(d) An HMO or preferred provider benefit plan must issue and transmit a determination indicating whether the proposed medical or health care services are preauthorized. This determination must be issued and transmitted once a preauthorization request for proposed services that require preauthorization is received from a preferred provider. The HMO or preferred provider benefit plan must respond to a request for preauthorization within the following time periods:

(1) For services not included under paragraphs (2) and (3) of this subsection, a determination must be issued and transmitted not later than the third calendar day after the date the request is received by the HMO or preferred provider benefit plan. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections (e) and (f) of this section, the determination must be issued and transmitted within three calendar days from the beginning of the next time period requiring appropriate personnel.

(2) If the proposed medical or health care services are for concurrent hospitalization care, the HMO or preferred provider benefit plan must issue and transmit a determination indicating whether proposed services are preauthorized within 24 hours of receipt of the request, followed within three working days after the transmittal of the determination by a letter notifying the enrollee or the individual acting on behalf of the enrollee and the provider of record of an adverse determination. If the request for medical or health care services for concurrent hospitalization care is received outside of the period requiring the availability of appropriate personnel as required in subsections (e) and (f) of this section, the determination must be issued and transmitted within 24 hours from the beginning of the next time period requiring appropriate personnel.

(3) If the proposed medical care or health care services involve post-stabilization treatment, or a life-threatening condition as defined in §19.1703 of this title (relating to Definitions), the HMO or preferred provider benefit plan must issue and transmit a determination indicating whether proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the enrollee, but in no case to exceed one hour from receipt of the request. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections (e) and (f) of this section, the determination must be issued and transmitted within one hour from the beginning of the next time period requiring appropriate personnel. The determination must be provided to the provider of record. If the HMO or preferred provider benefit plan issues an adverse determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, the HMO or preferred provider benefit plan must provide to the enrollee or individual acting on behalf of the enrollee, and the enrollee's provider of record, the notification required by §19.1717(a) and (b) of this title (relating to Independent Review of Adverse Determinations).

(e) A preferred provider may request a preauthorization determination via telephone from the HMO or preferred provider benefit plan. An HMO or preferred provider benefit plan must have appropriate personnel as described in §19.1706 of this title (relating to Requirements and Prohibitions Relating to Personnel) reasonably available at a toll-free telephone number to provide the determination between 6:00 a.m. and 6:00 p.m., Central Time, Monday through Friday on each day that is not a legal holiday and between 9:00 a.m. and noon, Central Time, on Saturday, Sunday, and legal holidays. An HMO or preferred provider benefit plan must have a telephone system capable of accepting or recording incoming requests after 6:00 p.m., Central Time, Monday through Friday and after noon, Central Time, on Saturday, Sunday, and legal holidays and must acknowledge each of those calls not later than 24 hours after the call is received. An HMO or preferred provider benefit plan providing a preauthorization determination under subsection (d) of this section must, within three calendar days of receipt of the request, provide a written notification to the preferred provider.

(f) An HMO providing routine vision services or dental health care services as a single health care service plan is not required to comply with subsection (e) of this section with respect to those services. An HMO providing routine vision services or dental health care services as a single health care service plan must:

(1) have appropriate personnel as described in §19.1706 of this title reasonably available at a toll-free telephone number to provide the preauthorization determination between 8:00 a.m. and 5:00 p.m., Central Time, Monday through Friday on each day that is not a legal holiday;

(2) have a telephone system capable of accepting or recording incoming requests after 5:00 p.m., Central Time, Monday through Friday and all day on Saturday, Sunday, and legal holidays, and must acknowledge each of those calls not later than the next working day after the call is received; and

(3) when providing a preauthorization determination under subsection (d) of this section, within three calendar days of receipt of the request, provide a written notification to the preferred provider.

(g) If an HMO or preferred provider benefit plan has preauthorized medical care or health care services, the HMO or preferred provider benefit plan may not deny or reduce payment to the physician or provider for those services based on medical necessity or appropriateness, or the experimental or investigational nature, of care unless the physician or provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the preauthorized medical or health care services.

(h) If an HMO or preferred provider benefit plan issues an adverse determination in response to a request made under subsection (d) of this section, a notice consistent with the provisions of §19.1709 of this title (relating to Notice of Determinations Made in Utilization

Review) and §19.1710 of this title (relating to Requirements Prior to Issuing Adverse Determination) must be provided to the enrollee or an individual acting on behalf of the enrollee, and the enrollee's provider of record. An enrollee, an individual acting on behalf of the enrollee, or the enrollee's provider of record may appeal any adverse determination under §19.1711 of this title (relating to Written Procedures for Appeal of Adverse Determination).

(i) This section applies to an agent or other person with whom an HMO or preferred provider benefit plan contracts to perform utilization review, or to whom the HMO or preferred provider benefit plan delegates the performance of preauthorization of proposed medical or health care services. Delegation of preauthorization services does not limit in any way the HMO or preferred provider benefit plan's responsibility to comply with all statutory and regulatory requirements.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 31, 2013.

TRD-201300375
Sara Waitt
General Counsel
Texas Department of Insurance
Effective date: February 20, 2013
Proposal publication date: August 24, 2012
For further information, please call: (512) 463-6327

♦ ♦ ♦

SUBCHAPTER U. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER WORKERS' COMPENSATION INSURANCE COVERAGE

28 TAC §§19.2001 - 19.2017

STATUTORY AUTHORITY. The new sections are adopted under Insurance Code Chapter 4201 (Utilization Review Agents), §38.001 (Data Collection and Reports: Inquiries), §843.151 (Regulation of Health Maintenance Organizations: Rules), §1301.007 (Preferred Provider Benefit Plans: Rules), §1305.007 (Workers' Compensation Health Care Networks: Rules), §1352.003(g) (Brain Injury: Required Coverages-Health Benefit Plans Other than Small Employer Health Benefit Plans), §1352.004(b) (Brain Injury: Training for Certain Personnel Required), §1369.057 (Benefits Related to Prescription Drugs and Devices and Related Services: Rules), and Insurance Code §36.001 (Department Rules and Procedures: General Rulemaking Authority).

Additionally, the new sections are adopted under Labor Code §401.011 (Definitions: General Definitions); Chapter 402 (Operation and Administration of Workers' Compensation System), including §§402.00111(b) (Relationship between Commissioner of Insurance and Commissioner of Workers' Compensation; Separation of Authority; Rulemaking), 402.00116 (Chief Executive), 402.00128 (General Powers and Duties of Commissioner), and 402.061 (Adoption of Rules); Chapter 408 (Workers' Compensation Benefits), including §§408.0043 (Professional Specialty Certification Required for Certain Review), 408.0044 (Review of Dental Services), 408.0045 (Review of Chiropractic Services), 408.0046 (Rules), 408.021 (Entitlement to Medical Benefits), 408.023 (List of Approved Doctors; Duties of Treating Doctors), and 408.0231 (Maintenance of List of Approved Doctors; Sanctions and Privileges Relating to Health Care); §412.0215 (Sanctions); Chapter 413 (Medical Review), including §§413.011 (Reimbursement Policies and Guidelines; Treatment Guidelines and Protocols), 413.014 (Preauthorization Requirements; Concurrent Review and Certification of Health Care), 413.015 (Payment by Insurance Carriers; Audit and Review), 413.017 (Presumption of Reasonableness), 413.031 (Medical Dispute Resolution), 413.0511 (Medical Advisor), 413.0512 (Medical Quality Review Panel), 413.0513 (Confidentiality Requirements), 413.052 (Production of Documents); and the Occupations Code §155.001 (License to Practice Medicine: Examination Required).

The purpose of Chapter 4201 is stated in Subchapter A §4201.001, which is to: (i) promote the delivery of quality health care in a cost-effective manner; (ii) ensure that a URA adheres to reasonable standards for conducting utilization review; (iii) foster greater coordination and cooperation between a health care provider and URA; (iv) improve communications and knowledge of benefits among all parties concerned before an expense is incurred; and (v) ensure that a URA maintains the confidentiality of medical records in accord with applicable law.

Insurance Code §4201.002 defines the various terms used in the chapter, among them "adverse determination" in §4201.002(1) and "utilization review" in §4201.002(13), which are incorporated into the adopted rules. Section 4201.003 provides that the commissioner of insurance may adopt rules to implement Insurance Code Chapter 4201. Section 4201.004 specifies the statutory requirements concerning telephone access to a URA.

Subchapter B (Applicability of Chapter) of Chapter 4201 addresses persons providing information about scope of coverage or benefits; certain contracts with the federal government; Medicaid and certain other state health or mental health programs; workers' compensation benefits; health care service provided under automobile insurance policies; employee welfare benefit plans; HMOs; and insurers. Regarding workers' compensation benefits, §4201.054(a) provides, in relevant part, "The commissioner of workers' compensation shall regulate as provided by this chapter a person who performs utilization review of a medical benefit provided under Title 5, Labor Code." Section 4201.054(c) also states, "Title 5, Labor Code, prevails in the event of a conflict between this chapter and Title 5, Labor Code." Section 4201.054(d) further provides, "The commissioner of workers' compensation may adopt rules as necessary to implement this section."

Subchapter C (Certification) specifies that a certification of registration is required to conduct utilization review, requirements for certification, certificate renewal, certification and renewal forms, fees, non-transferability of certificate, reporting material changes, and list of URAs. Section 4201.101 provides, "A utilization review agent may not conduct utilization review unless the commissioner issues a certificate of registration to the agent under this subchapter." Further, §4201.102(a) provides, "The commissioner may issue a certificate of registration only to an applicant who has met all the requirements of this chapter and all the applicable rules adopted by the commissioner."

Subchapter D (Utilization Review: General Standards) sets forth statutory standards regarding utilization review plans under §4201.151; the mandate under §4201.152 that a utilization review must be under the direction of a physician licensed to

practice medicine by a state licensing agency in the United States; and the mandate under §4201.153 that screening criteria be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow a deviation from the norm when justified on a case-by-case basis. Section 4201.154 provides for review and inspection of screening criteria and review procedures. Section 4201.155 provides that a URA may not establish or impose a notice requirement or other review procedure that is contrary to the requirements of the health insurance policy or health benefit plan.

Subchapter E (Utilization Review: Relations with Patients and Health Care Providers) §§4201.201, 4201.202, 4201.203, 4201.204, 4201.205, 4201.206, and 4201.207 address utilization review relations with patients and health care providers, including repetitive contacts; frequency of reviews; observing or participating in patient's care; mental health therapy; complaint system of the URA; designated initial contact; and opportunity to discuss treatment before issuance of adverse determination.

Subchapter F (Utilization Review: Personnel) §§4201.251, 4201.252, and 4201.253 address personnel matters, including delegation of utilization review, appropriate training, qualification of employed or contracted personnel, and prohibited bases for employment, compensation, evaluation, or performance standards.

Subchapter G (Notice of Determinations) specifies the general duty to notify under §4201.301, the general time for notice under §4201.302, what the contents of the notice of an adverse determination must include under §4201.303, the timeframes for notice of adverse determination under §4201.304, and what the notice of adverse determination for retrospective utilization review must include under §4201.305.

Subchapter H (Appeal of Adverse Determination) specifies the procedure for appeal of an adverse determination, including a provision in §4201.351 that for purposes of Subchapter H, a complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination. Section 4201.352 requires a URA to maintain and make available a written description of the procedures for appealing an adverse determination, and §4201.353 mandates that these procedures be reasonable. Subchapter H further addresses requirements for persons or entities that may appeal in §4201.354, acknowledgement of appeal in §4201.355, specialty review procedures in §4201.356, expedited appeal for denial of emergency care or continued hospitalization in §4201.357, response letter to interested persons in §4201.358, written notice to the appealing party of the determination of the appeal as soon as practicable in §4201.359, and immediate appeal to an IRO in life-threatening circumstances in §4201.360.

Subchapter I (Independent Review of Adverse Determination) sets forth the statutory requirements for the independent review of an adverse determination, addresses the review by the IRO and the URA's compliance with the independent determination in §4201.401, the information a URA must provide to the appropriate IRO in §4201.402, and payment for independent review in §4201.403.

Subchapter J (Specialty Utilization Review Agents) §4201.451 specifies definitions and requirements governing URAs that conduct utilization review for a specialty health care service, including dentistry, chiropractic services, or physical therapy.

Subchapter K (Claims Review of Medical Necessity and Appropriateness) of Chapter 4201 was repealed effective September 1, 2009.

Subchapter L (Confidentiality of Information; Access to Other Information) addresses general confidentiality requirements, consent requirements, providing information to affiliated entities, providing information to the commissioner of insurance, access to recorded personal information, publishing information identifiable to a health care provider, the requirement to maintain data in a confidential manner, and the destruction of certain confidential documents.

Subchapter M (Enforcement) concerns notice of suspected violation, compelling production of information, enforcement proceedings, and remedies and penalties for violation. Section 4201.602 authorizes the commissioner of insurance to initiate a proceeding under Subchapter M, which is a contested case for purposes of Government Code Chapter 2001. Under §4201.603, the commissioner of insurance may impose remedies and penalties for violations of Chapter 4201, including a sanction under Chapter 82, an issuance of a cease and desist order under Chapter 83, or an assessment of an administrative penalty under Chapter 84.

Insurance Code §38.001 provides, in relevant part, that TDI may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (i) the person's business condition; or (ii) any matter connected with the person's transactions that TDI considers necessary for the public good or for the proper discharge of TDI's duties.

Insurance Code §843.151 provides, in relevant part, that the commissioner of insurance may adopt reasonable rules as necessary and proper to implement Insurance Code Chapter 843.

Insurance Code §1301.007 requires, in relevant part, the commissioner of insurance to adopt rules as necessary to implement Insurance Code Chapter 1301.

Insurance Code §1305.007 provides that the commissioner of insurance may adopt rules as necessary to implement Insurance Code Chapter 1305.

Insurance Code §1352.003(g) requires the commissioner of insurance to adopt rules as necessary to implement Insurance Code Chapter 1352.

Insurance Code §1352.004(b) requires the commissioner of insurance by rule to require a health benefit plan issuer to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan.

Insurance Code §1369.057 provides that the commissioner of insurance may adopt rules to implement Insurance Code Chapter 1369, Subchapter B (Coverage of Prescription Drugs Specified by Drug Formulary).

Insurance Code §36.001 provides that the commissioner of insurance may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

Labor Code §401.011 specifies definitions used in the Texas Workers' Compensation Act. In particular, §401.011(17) defines the term "doctor"; §401.011(19) defines the term "health care," which includes a prescription drug, medicine, or other remedy under §401.011(19)(E); §401.011(20) defines "health care facility"; and §401.011(22-a) defines the terminology "health care

reasonably required." Section 401.011(27) defines the term "insurance carrier"; §401.011(28) defines "insurance company"; and §401.011(44) defines "workers' compensation insurance coverage."

Labor Code §402.00111(b) provides that the commissioner of insurance may delegate to the commissioner of workers' compensation or to that person's designee and may redact any delegation, and the commissioner of workers' compensation may delegate to the commissioner of insurance or to that person's designee, any power or duty regarding workers' compensation imposed on the commissioner of insurance or the commissioner of workers' compensation under Labor Code Title 5, including the authority to make final orders or decisions. The delegation must be made in writing.

Labor Code §402.00116 grants the powers and duties of chief executive and administrative officer to the commissioner of workers' compensation and the authority to administer and enforce Labor Code Title 5, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to TDI-DWC or the commissioner of workers' compensation.

Labor Code §402.00128 vests general operational powers in the commissioner of workers' compensation to conduct daily operations of TDI-DWC and implement policy, including the authority to delegate, assess, and enforce penalties and enter appropriate orders as authorized by Labor Code Title 5.

Labor Code §402.061 grants the commissioner of workers' compensation the authority to adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act.

Labor Code §412.0215(a) provides that TDI-DWC may impose sanctions against any person regulated by TDI-DWC.

Labor Code §408.0043(a) applies to a person, other than a chiropractor or dentist, who performs health care services under Labor Code Title 5, as a doctor performing peer reviews, utilization reviews, independent reviews, required medical examinations, or who serves on the medical quality review panel or as a designated doctor for TDI-DWC. Labor Code §408.0043(b) requires that a person described by Labor Code §408.0043(a), who reviews a specific workers' compensation case, hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving.

Labor Code §408.0044 pertains to dentists who perform dental services under Labor Code Title 5 for peer reviews, utilization reviews, independent reviews, or required dental examinations. Labor Code §408.0044(b) requires that a dentist who reviews a dental service in conjunction with a specific workers' compensation case be licensed to practice dentistry.

Labor Code §408.0045 pertains to chiropractors who perform chiropractic services under Labor Code Title 5 for peer reviews, utilization reviews, independent reviews, required medical examinations, or who serve on the medical quality review panel or as designated doctors providing chiropractic services for TDI-DWC. Labor Code §408.0045(b) requires that a chiropractor who reviews a chiropractic service in conjunction with a specific workers' compensation case be licensed to engage in the practice of chiropractic services.

Labor Code §408.0046 authorizes the commissioner of workers' compensation to adopt rules as necessary to determine which professional health practitioner specialties are appropriate for treatment of certain compensable injuries, and the rules must require an entity requesting a peer review to obtain and provide to the doctor providing the peer review services all relevant and updated medical records. Labor Code §408.021(a) specifies that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed.

Labor Code §408.023(h) requires that a URA or an insurance carrier that uses doctors to perform reviews of health care services provided under Labor Code Title 5, Subtitle A, including utilization review, only use doctors licensed to practice in this state. Section 408.023(n) requires the commissioner of workers' compensation to adopt rules to establish reasonable requirements for doctors and health care providers financially related to those doctors, including training, impairment rating testing, financial disclosure, and monitoring.

Labor Code §408.0231(g) requires the commissioner of workers' compensation to adopt rules regarding doctors who perform peer review functions for insurance carriers. Those rules may include standards for peer review; imposition of sanctions on doctors performing peer review functions, including restriction, suspension, or removal of the doctor's ability to perform peer review on behalf of insurance carriers in the workers' compensation system; and other issues important to the quality of peer review, as determined by the commissioner.

Labor Code §413.011 requires the commissioner of workers' compensation by rule to establish medical policies and guidelines relating to necessary treatment for injuries designed to ensure the quality of medical care and achieve effective medical cost control.

Labor Code §413.014 requires preauthorization by insurance carriers for specified health care treatments and services. Section 413.014(a) defines the terminology "investigational or experimental service or device."

Labor Code §413.015 requires insurance carriers to pay for medical services as provided in the statute and requires that TDI-DWC ensure compliance with the medical policies and fee guidelines through audit and review.

Labor Code §413.017 provides a presumption of reasonableness for medical services consistent with TDI-DWC medical policies and fee guidelines and medical services that are provided subject to prospective, concurrent, or retrospective review as required by TDI-DWC policies and authorized by the insurance carrier.

Labor Code §413.031(d) provides that a review of the medical necessity of a health care service requiring preauthorization under §413.014 or commissioner of workers' compensation rules promulgated under §413.014 or §413.011(g) be conducted by an IRO under Insurance Code Chapter 4202 in the same manner as reviews of utilization review decisions by HMOs.

Labor Code §413.0511(b) provides that the TDI-DWC medical advisor shall make recommendations regarding the adoption of rules and policies relating to medical benefits as required by the commissioner of workers' compensation.

Labor Code §413.0512(a) requires the TDI-DWC medical advisor to establish a medical quality review panel of health care providers to assist the medical advisor in performing the required duties under §413.0511.

Labor Code §413.0513(a) provides that information collected, assembled, or maintained by or on behalf of TDI-DWC under

§413.0511 or §413.0512 constitutes an investigation file and may not be disclosed.

Labor Code §413.052 provides that the commissioner of workers' compensation by rule shall establish procedures to enable TDI-DWC to compel the production of documents.

Labor Code §504.053(b)(2) provides that if a political subdivision or a pool determines that a workers' compensation health care network certified under Insurance Code Chapter 1305 is not available or practical for the political subdivision or pool, the political subdivision or pool may provide medical benefits to its injured employees or to the injured employees of the members of the pool by directly contracting with health care providers or by contracting through a health benefits pool established under Local Government Code Chapter 172.

Labor Code §504.055(b) provides that §504.055 applies only to a first responder who sustains a serious bodily injury, as defined by Penal Code §1.07, in the course and scope of employment.

Labor Code §504.055(c), states that, "The political subdivision, division, and insurance carrier shall accelerate and give priority to an injured first responder's claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury described by Subsection (b)."

Labor Code §504.056 provides that the purpose of Labor Code §504.055 is to ensure that an injured first responder's claim for medical benefits is accelerated by a political subdivision, insurance carrier, and the division to the full extent authorized by current law.

The Occupations Code §155.001 provides that a person may not practice medicine in this state unless the person holds a license issued under Occupations Code, Title 3, Subtitle B.

§19.2002. Applicability.

(a) Limitations on applicability. Except as provided in Insurance Code Chapter 4201, this subchapter applies to utilization review performed under workers' compensation insurance coverage. This subchapter does not affect the authority of TDI-DWC to exercise the powers granted to it under Labor Code Title 5 and Insurance Code Chapter 4201. This subchapter applies to utilization review as set forth in Insurance Code Chapters 1305 and 4201 and Labor Code Title 5.

(1) This subchapter does not apply to utilization review performed under a health benefit plan or a health insurance policy.

(2) This subchapter does not apply to a person who provides information to an injured employee or an injured employee's representative, physician, doctor, or other health care provider about scope of coverage or benefits provided for under workers' compensation insurance coverage, and does not determine medical necessity or appropriateness or the experimental or investigational nature of health care services.

(b) Applicability of other law.

(1) Health care providers performing peer reviews regarding the prospective, concurrent, or retrospective review of the medical necessity or appropriateness of health care are performing utilization review, must generate a written report, and must comply with this subchapter, Labor Code Title 5, and rules adopted under the Texas Workers' Compensation Act including, but not limited to, Chapter 180 of this title (relating to Monitoring and Enforcement).

(2) Insurance carriers must process medical bills as required by Labor Code Title 5 and rules adopted under the Texas Workers' Compensation Act including, but not limited to, Chapter 133, Subchapter A, of this title (relating to General Rules for Medical Billing and Processing).

(3) If there is a conflict between this subchapter and rules adopted by the commissioner of workers' compensation, the rules adopted by the commissioner of workers' compensation prevail.

(4) If there is a conflict between this subchapter and the rules in Chapter 10 of this title, regarding Workers' Compensation Health Care Networks, the rules in Chapter 10 of this title prevail.

§19.2003. Definitions.

(a) The words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in this subchapter, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Adverse determination--A determination by a URA made on behalf of a payor that the health care services provided or proposed to be provided to an injured employee are not medically necessary or appropriate. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. For the purposes of this subchapter, an adverse determination does not include a determination that health care services are experimental or investigational.

(2) Appeal--The URA's formal process by which an injured employee, an injured employee's representative, or an injured employee's provider of record may request reconsideration of an adverse determination. For the purposes of this subchapter the term also applies to reconsideration processes prescribed by Labor Code Title 5 and applicable rules for workers' compensation.

(3) Biographical affidavit--National Association of Insurance Commissioners biographical affidavit to be used as an attachment to the URA application.

(4) Certificate--A certificate issued by the commissioner to an entity authorizing the entity to operate as a URA in the State of Texas. A certificate is not issued to an insurance carrier that is registered as a URA under §19.2004 of this title (relating to Certification or Registration of URAs).

(5) Commissioner--As defined in Insurance Code §31.001.

(6) Compensable injury--As defined in Labor Code §401.011.

(7) Complaint--An oral or written expression of dissatisfaction with a URA concerning the URA's process in conducting a utilization review. The term "complaint" does not include:

(A) an expression of dissatisfaction constituting an appeal under Insurance Code §4201.351; or

(B) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to the satisfaction of the complaining party.

(8) Concurrent utilization review--A form of utilization review for ongoing health care or for an extension of treatment beyond previously approved health care.

(9) Disqualifying association--Any association that may reasonably be perceived as having potential to influence the conduct

or decision of a reviewing physician, doctor, or other health care provider, which may include:

(A) shared investment or ownership interest;

(B) contracts or agreements that provide incentives, for example, referral fees, payments based on volume or value, or waiver of beneficiary coinsurance and deductible amounts;

(C) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, or warranties, or any other services related to the management of a physician's, doctor's, or other health care provider's practice;

(D) personal or family relationships; or

(E) any other financial arrangement that would require disclosure under Labor Code or applicable TDI-DWC rules, Insurance Code or applicable TDI rules, or any other association with the injured employee, employer, or insurance carrier that may give the appearance of preventing the reviewing physician, doctor, or other health care provider from rendering an unbiased opinion.

(10) Doctor--As defined in Labor Code §401.011.

(11) Experimental or investigational--A health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care.

(12) Health care--As defined in Labor Code §401.011.

(13) Health care facility--As defined in Labor Code §401.011.

(14) Insurance carrier or insurer--As defined in Labor Code §401.011.

(15) Independent review organization or IRO--As defined in §12.5 of this title (relating to Definitions).

(16) Legal holiday--

(A) a holiday as provided in Government Code §662.003(a);

(B) the Friday after Thanksgiving Day;

(C) December 24; and

(D) December 26.

(17) Medical benefit--As defined in Labor Code §401.011.

(18) Medical emergency--The sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the injured employee's health or bodily functions in serious jeopardy; or

(B) serious dysfunction of any body organ or part.

(19) Medical records--The history of diagnosis of and treatment for an injury, including medical, mental health records as allowed by law, dental, and other health care records from all disciplines providing care to an injured employee.

(20) Mental health medical record summary--A summary of process or progress notes relevant to understanding the injured employee's need for treatment of a mental or emotional condition or disorder including:

(A) identifying information; and

(B) a treatment plan that includes a:

(i) diagnosis;

(ii) treatment intervention;

(iii) general characterization of injured employee behaviors or thought processes that affect level of care needs; and

(iv) discharge plan.

(21) Mental health therapist--Any of the following individuals who, in the ordinary course of business or professional practice, as appropriate, diagnose, evaluate, or treat any mental or emotional condition or disorder:

(A) an individual licensed by the Texas Medical Board to practice medicine in this state;

(B) an individual licensed as a psychologist, psychological associate, or a specialist in school psychology by the Texas State Board of Examiners of Psychologists;

(C) an individual licensed as a marriage and family therapist by the Texas State Board of Examiners of Marriage and Family Therapists;

(D) an individual licensed as a professional counselor by the Texas State Board of Examiners of Professional Counselors;

(E) an individual licensed as a social worker by the Texas State Board of Social Worker Examiners;

(F) an individual licensed as a physician assistant by the Texas Medical Board;

(G) an individual licensed as a registered professional nurse by the Texas Board of Nursing; or

(H) any other individual who is licensed or certified by a state licensing board in the State of Texas, as appropriate, to diagnose, evaluate, or treat any mental or emotional condition or disorder.

(22) Mental or emotional condition or disorder--A mental or emotional illness as detailed in the most current Diagnostic and Statistical Manual of Mental Disorders.

(23) Payor--Any person or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits, including workers' compensation benefits, to an individual treated by a health care provider under a policy, plan, statute, or contract.

(24) Peer review--An administrative review by a health care provider performed at the insurance carrier's request without a physical examination of the injured employee.

(25) Person--Any individual, partnership, association, corporation, organization, trust, hospital district, community mental health center, mental retardation center, mental health and mental retardation center, limited liability company, limited liability partnership, a political subdivision of this state, the statewide rural health care system under Insurance Code Chapter 845, and any similar entity.

(26) Preauthorization--A form of prospective utilization review by a payor or a payor's URA of health care services proposed to be provided to an injured employee.

(27) Provider of record--The physician, doctor, or other health care provider that has primary responsibility for the health care services rendered or requested on behalf of an injured employee, or a physician, doctor, or other health care provider that has rendered or has been requested to provide health care services to an injured employee.

This definition includes any health care facility where health care services are rendered on an inpatient or outpatient basis.

(28) Reasonable opportunity--At least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day prior to issuing a prospective utilization review adverse determination;

(B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or

(C) prior to issuing a concurrent or post-stabilization review adverse determination.

(29) Registration--The process for an insurance carrier to register with TDI to perform utilization review solely for injured employees covered by workers' compensation insurance coverage issued by the insurance carrier.

(30) Request for a review by an IRO--Form to request a review by an independent review organization that is completed by the requesting party and submitted to the URA, or insurance carrier that made the adverse determination.

(31) Retrospective utilization review--A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

(32) Screening criteria--The written policies, decision rules, medical protocols, or treatment guidelines used by a URA as part of the utilization review process.

(33) TDI--The Texas Department of Insurance.

(34) TDI-DWC--The Texas Department of Insurance, Division of Workers' Compensation.

(35) Texas Workers' Compensation Act--Labor Code Title 5, Subtitle A.

(36) Treating doctor--As defined in Labor Code §401.011.

(37) URA--Utilization review agent.

(38) URA application--Form for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state.

(39) Workers' compensation health care network--As defined in Insurance Code §1305.004.

(40) Workers' compensation health plan--Health care provided by a political subdivision contracting directly with health care providers or through a health benefits pool, under Labor Code §504.053(b)(2).

(41) Workers' compensation insurance coverage--As defined in Labor Code §401.011.

(42) Workers' compensation network coverage--Health care provided under a workers' compensation health care network.

(43) Workers' compensation non-network coverage--Health care delivered under Labor Code Title 5, excluding health care provided under Insurance Code Chapter 1305.

§19.2004. Certification or Registration of URAs.

(a) Applicability of certification or registration requirements. A person acting as or holding itself out as a URA under this subchapter must be certified or registered, as applicable, under Insurance Code §§4201.057, 4201.058, 4201.101, and this subchapter.

(1) If an insurance carrier performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, the insurance carrier must be certified.

(2) If an insurance carrier performs utilization review only for coverage for which it is the payor, the insurance carrier must be registered.

(b) Application form. The commissioner adopts by reference the:

(1) URA application, for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state; and

(2) Biographical affidavit, to be used as an attachment to the URA application.

(c) Original application fee. The original application fee specified in §19.802 of this title (relating to Amount of Fees) must be sent to TDI with the application for certification. A person applying for registration is not required to pay a fee.

(d) Where to obtain and send the URA application form. Forms may be obtained from www.tdi.texas.gov/forms and must be sent to: Texas Department of Insurance, Managed Care Quality Assurance Office, Mail Code 103-6A, P.O. Box 149104, Austin, Texas 78714-9104.

(e) Original application process. Within 60 calendar days after receipt of a complete application, TDI will process the application and issue or deny a certification or registration. TDI will send a certificate or a letter of registration to an entity that is granted certification or registration. The applicant may waive the time limit described in this subsection.

(f) Omissions or deficiencies. TDI will send the applicant written notice of any omissions or deficiencies in the application. The applicant must correct the omissions or deficiencies in the application, or request additional time in writing, within 15 working days of the date of TDI's latest notice of omissions or deficiencies. If the applicant fails to do so, the application will not be processed and the file will be closed as an incomplete application. The application fee is not refundable. The request for additional time must be approved by TDI in writing to be effective.

(g) Certification and registration expiration. Each URA registration or certification issued by TDI and not suspended or revoked by the commissioner expires on the second anniversary of the date of issuance.

(h) Renewal requirements. A URA must apply for renewal of certification or registration every two years from the date of issuance by submitting the URA application to TDI. A URA must also submit a renewal fee in the amount specified by §19.802 of this title for renewal of a certification. A person applying for renewal of a registration is not required to pay a fee.

(1) Continued operation during review. If a URA submits the required information and fees specified in this subsection on or before the expiration of the certification or registration, the URA may continue to operate under its certification or registration until the renewal certification or registration is denied or issued.

(2) Expiration for 90 calendar days or less. If the certification or registration has been expired for 90 calendar days or less,

the URA may renew the certification or registration by sending a completed renewal application and fee as applicable. The URA may not operate from the time the certification or registration has expired until the time TDI has issued a renewal certification or registration.

(3) Expiration for longer than 90 calendar days. If a URA's certification or registration has been expired for longer than 90 calendar days, the URA may not renew the certification or registration. The URA must obtain a new certification or registration by submitting an application for original issuance of the certification or registration and an original application fee as applicable.

(i) Contesting a denial. If an application for an original or renewal certification or registration is denied, the applicant may contest the denial under the provisions of Chapter 1, Subchapter A, of this title (relating to Rules of Practice and Procedure) and Government Code Chapter 2001, concerning Administrative Procedure.

(j) Updating information on effective date. A URA that is certified or registered before the effective date of this rule must submit an updated application to TDI to comply with this subchapter within 90 calendar days after the effective date of this rule. However, the submission of an updated application does not change the URA's existing renewal date, and this section still governs the URA's renewal process.

§19.2005. General Standards of Utilization Review.

(a) Review of utilization review plan. A utilization review plan must be reviewed and approved by a physician and conducted under standards developed and periodically updated with input from both primary and specialty physicians, doctors, and other health care providers, including practicing health care providers, as appropriate.

(b) Special circumstances. A utilization review determination must be made in a manner that takes special circumstances of the case into account that may require deviation from the norm stated in the screening criteria or relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness. For the purposes of this section, disability must not be construed to mean an injured employee who is off work or receiving income benefits.

(c) Screening criteria. Each URA must utilize written screening criteria that are evidence-based, scientifically valid, outcome-focused, and that comply with the requirements in Insurance Code §4201.153. The screening criteria must also recognize that if evidence-based medicine is not available for a particular health care service provided, the URA must utilize generally accepted standards of medical practice recognized in the medical community. For workers' compensation network coverage, screening criteria must comply with Insurance Code Chapter 1305 and §10.101 of this title (relating to General Standards for Utilization Review and Retrospective Review); for workers' compensation non-network coverage and workers' compensation health plan, screening criteria must comply with Labor Code §§401.011, 413.011, and 413.014, and Chapters 133, 134, and 137 of this title (relating to General Medical Provisions; Benefits-Guidelines for Medical Services, Charges, and Payments; and Disability Management, respectively).

(d) Referral and determination of adverse determinations. Adverse determinations must be referred to and may only be determined by a physician, doctor, or other health care provider with appropriate credentials under Chapter 180 of this title (relating to Monitoring and Enforcement) and §19.2006 of this title (relating to Requirements and Prohibitions Relating to Personnel). Physicians and doctors performing utilization review must also comply with Labor Code §§408.0043, 408.0044, and 408.0045.

(e) Delegation of review. A URA, including a specialty URA, may delegate the utilization review to qualified personnel in a hospital or other health care facility in which the health care services to be reviewed were, or are, to be provided. The delegation does not relieve the URA of full responsibility for compliance with this subchapter, Insurance Code Chapter 4201, the Texas Workers' Compensation Act, and applicable TDI-DWC rules, including responsibility for the conduct of those to whom utilization review has been delegated.

(f) Complaint system. The URA must develop and implement procedures for the resolution of oral or written complaints initiated by injured employees, their representatives, or health care providers concerning the utilization review. The URA must maintain records of complaints for three years from the date the complaints are filed. The complaints procedure must include a requirement for a written response to the complainant by the agent within 30 calendar days. The written response must include TDI's address, toll-free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI.

(g) Compliance with Labor Code §504.055. Utilization review plan written policies must evidence compliance with Labor Code §504.055, concerning Expedited Provision of Medical Benefits for Certain Injuries Sustained by First Responder in Course and Scope of Employment.

§19.2006. Requirements and Prohibitions Relating to Personnel.

(a) Qualification requirements. Physicians, doctors, and other health care providers employed by or under contract with a URA to perform utilization review must be appropriately trained, qualified, and currently licensed. Personnel conducting utilization review must hold an unrestricted license or an administrative license in Texas or be otherwise authorized to provide health care services in Texas. Physicians and doctors conducting utilization review must hold a professional certification in a health care specialty appropriate to the type of health care the injured employee is receiving as required by Labor Code §§408.0043, 408.0044, and 408.0045. Physicians, doctors, and other health care providers conducting utilization review must have the appropriate credentials as required by Chapter 180 of this title (relating to Monitoring and Enforcement).

(1) This subchapter does not supersede requirements in the Medical Practice Act, Texas Medical Board rules, Texas Occupations Code Chapter 201 (relating to Chiropractors), or Texas Board of Chiropractic Examiners rules. Individuals licensed by the Texas Medical Board are subject to 22 TAC Chapter 190, regarding disciplinary guidelines.

(2) Personnel who perform clerical or administrative tasks are not required to have the qualifications prescribed by this subsection.

(b) Disqualifying associations. For purposes of this subsection, being employed by or under contract with the same URA as the physician, doctor, or other health care provider who issued the initial adverse determination does not in itself constitute a disqualifying association. A physician, doctor, or other health care provider who conducts utilization review must not have any disqualifying associations with the:

(1) injured employee or health care provider who is requesting utilization review or an appeal; or

(2) physician, doctor, or other health care provider who issued the initial adverse determination.

(c) Information a URA must send to TDI. A URA must send to TDI the name, type, Texas license number, and qualifications of the personnel either employed or under contract to perform utilization review with an original or renewal application.

(d) Written procedures and maintenance of records. A URA must develop and implement written procedures, and maintain documentation, to demonstrate that all physicians, doctors, and other health care providers used by the URA are licensed, qualified, and appropriately trained or experienced.

(e) Physician direction requirement. Utilization review conducted by a URA must be under the direction of a physician currently licensed without restriction to practice medicine in Texas. The physician must be employed by or under contract with the URA.

§19.2008. On-Site Review by a URA.

(a) Identification of URAs. If a URA's staff member is conducting an on-site or off-site review, each staff member must provide his or her name, the name of his or her organization, photo identification, and a URA identification card with the certification or registration number assigned by TDI when requested by an individual, including an injured employee or health care provider.

(b) On-site review. For on-site review conducted at a health care facility, a URA:

(1) must ensure that on-site review staff:

(A) register with the appropriate contact individual, if available, prior to requesting any clinical information or assistance from health care facility staff; and

(B) wear appropriate health care facility supplied identification tags while on the health care facility premises;

(2) must agree, if so requested, that the medical records remain available in the designated areas during the on-site review and that reasonable health care facility administrative procedures will be followed by on-site review staff to avoid disrupting health care facility operations or injured employee care. The procedures, however, should not obstruct or limit the ability of the URA to efficiently conduct the necessary review.

§19.2009. Notice of Determinations Made in Utilization Review.

(a) Notice requirements of favorable or adverse determinations.

(1) A URA must send written notification of a determination made in utilization review to the individuals specified in and within the timeframes required for utilization review.

(2) For prospective and concurrent review, the timeframes are specified by:

(A) Section 134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) for workers' compensation non-network coverage; and

(B) Insurance Code §1305.353, concerning Notice of Certain Utilization Review Determinations; Preauthorization Requirements; and §10.102 of this title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements) for workers' compensation network coverage.

(3) For retrospective review, the timeframes are specified by:

(A) Sections 133.240 and 133.250 of this title (relating to Medical Payment and Denials, and Reconsideration for Payment of Medical Bills, respectively) for workers' compensation non-network coverage;

(B) Sections 133.240, 133.250, and 10.102 of this title, for workers' compensation network coverage.

(4) For workers' compensation non-network coverage and network coverage, a URA must ensure that preauthorization numbers assigned by the URA comply with the data and format requirements contained in the standards adopted by the U.S. Department of Health and Human Services in 45 Code of Federal Regulations §162.1102 (relating to Standards for Health Care Claims or Equivalent Encounter Information Transaction) based on the type of service in the preauthorization request.

(b) Required notice elements. In all instances of a prospective, concurrent, or retrospective utilization review adverse determination, written notification of the adverse determination by the URA must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description of the procedure for filing a complaint with TDI;

(4) the professional specialty and Texas license number of the physician, doctor, or other health care provider that made the adverse determination;

(5) a description of the procedure for the URA's complaint system as required by §19.2005 of this title (relating to General Standards of Utilization Review);

(6) a description of the URA's appeal process, as required by §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determination) and a statement that in a circumstance involving an injured employee's life-threatening condition, the injured employee is entitled to an immediate review of the adverse determination by an IRO and is not required to comply with procedures for an internal review of the adverse determination by the URA for prospective and concurrent utilization review;

(7) for workers' compensation network coverage, a description or the source of the screening criteria used in making the determination, including a description of treatment guidelines used, as applicable;

(8) for workers' compensation non-network coverage, a description of treatment guidelines used under Chapter 137 of this title (relating to Disability Management) or Labor Code §504.054(b) in making a determination; and

(9) notice of the independent review process. The notice of the independent review process required under this paragraph must include:

(A) a statement that:

(i) the request for a review by an IRO form must be completed by the injured employee, the injured employee's representative, or the injured employee's provider of record and be returned to the insurance carrier or URA that made the adverse determination to begin the independent review process;

(ii) a request for independent review of an adverse determination made under workers' compensation non-network coverage must be timely filed by the requestor consistent with §133.308 of this title (relating to MDR of Medical Necessity Disputes); and

(iii) a request for independent review of an adverse determination made under workers' compensation network coverage must be timely filed by the requestor consistent with §10.104 of this title (relating to Independent Review of Adverse Determination); and

(B) either of the following:

(i) a copy of the request for a review by an IRO form, available at www.tdi.texas.gov/forms; or

(ii) notice in at least 12 point font that the injured employee can obtain a copy of the request for a review by an IRO form by:

(I) accessing TDI's website at www.tdi.texas.gov/forms; or

(II) calling {insert URA's telephone number} to request a copy of the form, at which time the URA will send a copy of the request for a review by an IRO form to the injured employee.

(c) Peer review reports. The notice of determination made in utilization review required under this section and the peer review report required by §180.28 of this title (relating to Peer Review Requirements, Reporting, and Sanctions) may be combined into one document if all the requirements of both sections are met.

§19.2010. Requirements Prior to Issuing Adverse Determination.

In any instance in which a URA is questioning the medical necessity or appropriateness of the health care services prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the injured employee with a physician, dentist, or chiropractor. If the health care services in question are dental services, then a dentist may conduct the discussion if the services in question are within the scope of the dentist's license to practice dentistry. If the health care services in question are chiropractic services, then a chiropractor may conduct the discussion if the services in question are within the scope of the chiropractor's license to practice chiropractic. The discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

(1) The URA must provide the URA's telephone number so the provider of record may contact the URA to discuss the pending adverse determination.

(2) The URA must maintain, and submit to TDI or TDI-DWC on request, documentation that details the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome.

§19.2011. Written Procedures for Appeal of Adverse Determinations.

(a) Appeal of prospective or concurrent review adverse determinations. Each URA must comply with its written procedures for appeals. The written procedures for appeals must comply with Insurance Code Chapter 4201, Subchapter H, concerning Appeal of Adverse Determination, and must include the following provisions:

(1) For workers' compensation network coverage, a URA must include in its written procedures a statement specifying the timeframes for requesting the appeal under Insurance Code §1305.354, which may not be less than 30 calendar days after the date of issuance of written notification of an adverse determination.

(2) For workers' compensation non-network coverage and workers' compensation health plans, a URA must include in its written procedures a statement specifying that the timeframes for requesting the appeal of the adverse determination must be consistent with §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) and Chapter 133, Subchapter D, of this title (relating to Dispute of Medical Bills).

(3) An injured employee, the injured employee's representative, or the provider of record may appeal the adverse determination orally or in writing.

(4) Appeal decisions must be made by a physician, dentist, or chiropractor who has not previously reviewed the case, as required by Chapter 180 of this title (relating to Monitoring and Enforcement); Insurance Code §1305.354; and §10.103 of this title (relating to Reconsideration of Adverse Determination). If the health care services in question are dental services, then a dentist may make the appeal decision if the services in question are within the scope of the dentist's license to practice dentistry. If the health care services in question are chiropractic services, then a chiropractor may make the appeal decision if the services in question are within the scope of the chiropractor's license to practice chiropractic.

(5) Subject to the notice requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review), in any instance in which the URA is questioning the medical necessity or appropriateness of the health care services, prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the injured employee with a physician. If the health care services in question are dental services, then a dentist may conduct the discussion if the services in question are within the scope of the dentist's license to practice dentistry. If the health care services in question are chiropractic services, then a chiropractor may conduct the discussion if the services in question are within the scope of the chiropractor's license to practice chiropractic. The provision must state that the discussion must include, at a minimum, the clinical basis for the URA's decision.

(6) After the URA has sought review of the appeal of the adverse determination, the URA must issue a response letter explaining the resolution of the appeal to individuals specified in §19.2009(a) of this title (relating to Notice of Determinations Made in Utilization Review).

(7) The response letter required in paragraph (6) of this subsection, for both workers' compensation network coverage and for workers' compensation non-network coverage, must include:

(A) a statement of the specific medical or dental reasons for the resolution;

(B) the clinical basis for the decision;

(C) the professional specialty and Texas license number of the physician, dentist, or chiropractor who made the determination;

(D) notice of the appealing party's right to seek review of the adverse determination by an IRO under §19.2017 of this title (relating to Independent Review of Adverse Determinations), the notice of the independent review process, and either of the following:

(i) a copy of the request for a review by an IRO form, available at www.tdi.texas.gov/forms; or

(ii) notice in at least 12 point font that the injured employee can obtain a copy of the request for a review by an IRO form by:

(I) accessing TDI's website, at www.tdi.texas.gov/forms; or

(II) calling {insert URA's telephone number} to request a copy of the form, at which time the URA will send a copy of the request for a review by an IRO form to the injured employee or health care provider;

(E) procedures for filing a complaint as described in §19.2005(f) of this title (relating to General Standards of Utilization Review);

(F) for workers' compensation network coverage only, a description or the source of the screening criteria that were utilized in making the determination, including a description of the network adopted treatment guidelines, if any; and

(G) for workers' compensation non-network coverage only, a description of treatment guidelines utilized under Chapter 137 of this title (relating to Disability Management) or Labor Code §504.054(b) in making a determination;

(8) Timeframes required for written notifications to the appealing party of the determination of the appeal:

(A) must be resolved as specified in §10.103 of this title for workers' compensation network coverage; and

(B) must be resolved as specified in §134.600 of this title for workers' compensation non-network coverage.

(9) In a circumstance involving an injured employee's life-threatening condition, or involving a request for a medical interlocutory order under §134.550 of this title (Medical Interlocutory Order), the injured employee is entitled to an immediate review by an IRO of the adverse determination and is not required to comply with procedures for an appeal of the adverse determination by the URA.

(b) Appeal of retrospective review adverse determinations. A URA must maintain and make available a written description of appeal procedures involving an adverse determination in a retrospective review. The appeal procedures must comply with §19.2009 of this title for retrospective utilization review adverse determination appeals and Insurance Code §4201.359. The written procedures for appeals must specify that an injured employee, the injured employee's representative, or the provider of record may appeal the adverse determination orally or in writing.

(1) Workers' compensation network coverage. For workers' compensation network coverage, appeal procedures must comply with the requirements in Insurance Code Chapter 1305, §10.102 of this title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements), and §133.250 of this title (relating to Reconsideration for Payment of Medical Bills).

(2) Workers' compensation non-network coverage. For workers' compensation non-network coverage, the appeal procedures must comply with the requirements of §133.250 of this title.

§19.2012. URA's Telephone Access and Procedures for Certain Drug Requests and Post-Stabilization Care.

(a) A URA must have appropriate personnel reasonably available by toll-free telephone at least 40 hours per week during normal business hours in both Central Time and Mountain Time, to discuss an injured employee's care and to respond to telephone review requests.

(b) A URA must have procedures that the URA will implement when responding to requests for:

(1) drugs that require preauthorization, in situations in which the injured employee has received or is currently receiving the requested drugs and an adverse determination could lead to a medical emergency; and

(2) post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment, as requested by the treating physician or provider of record.

§19.2013. Confidentiality.

(a) Confidentiality requirements. To ensure confidentiality, a URA must, when contacting a physician's, doctor's, or other health care provider's office, provide its certification number, name, and professional qualifications.

(1) If requested by the physician, doctor, or other health care provider, the URA must present written documentation that it is acting as an agent of the insurance carrier for the relevant injured employee.

(2) Medical records and injured employee specific information must be maintained by a URA in a secure area with access limited to essential personnel only.

(3) A URA must retain information generated and obtained by the URA in the course of utilization review for at least four years.

(4) A URA's charges for providing a copy of recorded personal information to individuals may not exceed 10 cents per page and may not include any costs that are otherwise recouped as part of the charge for utilization review.

(b) Written procedures on confidentiality.

(1) A URA must specify in writing the procedures the URA will implement pertaining to confidentiality of information received from the injured employee, the injured employee's representative, and the physician, doctor, or other health care provider and the information exchanged between the URA and third parties for conducting utilization review. These procedures must specify that:

(A) specific information received from the injured employee, the injured employee's representative, and the physician, doctor, or other health care provider and the information exchanged between the URA and third parties for the purpose of conducting reviews will be considered confidential, be used by the review agent solely for utilization review, and be shared by the URA with only those third parties who have authority to receive the information, for example, the claim administrator; and

(B) the URA has procedures in place to address confidentiality, and that the URA agrees to abide by any federal and state laws governing the issue of confidentiality.

(2) Summary data which does not provide sufficient information to allow identification of individual injured employees, physicians, doctors, or other health care providers is not considered confidential.

§19.2014. Regulatory Requirements Subsequent to Certification or Registration.

(a) Summary report to TDI. By March 1 of each year, each URA certified or registered under this subchapter must submit to TDI through TDI's Internet website a complete summary report of information related to complaints, adverse determinations, and appeals of adverse determinations.

(b) Contents of summary report. The summary report required by this section must cover reviews performed by the URA during the preceding calendar year and must include:

(1) the total number of written notices of adverse determinations;

(2) a listing of adverse determinations for preauthorization, by the medical condition and treatment using the physical diagnosis or DSM-IV (mental health diagnosis) coding that is in effect at the time, or successor codes and modifiers, and CPT (procedure) code or

other relevant procedure code if a CPT designation is not available, or any other nationally recognized numerically codified diagnosis or procedure;

(3) the classification of the party requesting review, for example, a health care provider; injured employee; or their representative;

(4) the disposition of the appeal of adverse determination (either in favor of the appellant, or in favor of the original utilization review determination) at each level within the internal utilization review process; and

(5) the subject matter of any complaint filed with the URA.

(c) Complaints included in summary report. Complaints listed in the summary report under subsection (b)(5) of this section must be categorized as follows:

(1) administration, for example, copies of medical records not paid for, too many calls or written requests for information from provider, and too much information requested from provider;

(2) qualifications of URA's personnel; or

(3) appeal or complaint process, for example, a treating physician unable to discuss the plan of treatment with a utilization review physician; no notice of adverse determination; no notice of clinical basis for adverse determination; or written procedures for appeal not provided.

(d) Complaints to TDI. Complaints received by TDI against a URA must be processed under TDI's established procedures for investigation and resolution of complaints.

(e) TDI inquiries. TDI may address inquiries to a URA related to any matter connected with URA transactions TDI considers necessary for the public good or for the proper discharge of TDI's duties. Under Insurance Code §38.001, a URA that receives an inquiry from TDI must respond to the inquiry in writing not later than the 10th calendar day after the date the inquiry is received.

(f) TDI-DWC inquiries. This section does not limit the ability of the commissioner of workers' compensation or TDI-DWC to make inquiries, conduct audits, or receive and investigate complaints against URAs or personnel employed by or under contract with URAs to perform utilization review to determine compliance with or violations of Labor Code Title 5, Insurance Code, or applicable TDI-DWC rules.

(g) On-site review by TDI. For scheduled and unscheduled on-site reviews, TDI may make a complete on-site review of the operations of each URA at the principal place of business for each agent as often as is deemed necessary. An on-site review will only be conducted during working days and normal business hours. A URA must make available all records relating to its operation during any scheduled or unscheduled on-site reviews.

(1) Scheduled on-site reviews. A URA will be notified of any scheduled on-site review by letter, which will specify, at a minimum, the identity of TDI's designated representative and the expected arrival date and time.

(2) Unscheduled on-site reviews. At a minimum, notice of an on-site review of a URA will be in writing and be presented by TDI's designated representative on arrival.

§19.2017. Independent Review of Adverse Determinations.

(a) Life-threatening conditions.

(1) Notification for life-threatening conditions. For life-threatening conditions, notification of an adverse determination by a URA must comply with:

(A) Section 134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) for workers' compensation non-network coverage;

(B) Insurance Code §1305.353 and §10.102 of this title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements) for workers' compensation network coverage; and

(C) Section 19.2009(a)(2) of this title (relating to Notice of Determinations Made in Utilization Review), including notice of the independent review process and the procedure for obtaining a copy of the request for a review by an IRO form. The notice must describe how to obtain independent review of the adverse determination and how TDI assigns a request for independent review to an IRO.

(2) Existence of life-threatening condition. An injured employee, the injured employee's representative, or the injured employee's provider of record must determine the existence of a life-threatening condition on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the injured employee's disease or condition is a life-threatening condition.

(3) Appeal of adverse determination involving life-threatening condition. Any party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination involving a life-threatening condition is denied by the URA may seek review of the adverse determination by an IRO assigned under Insurance Code Chapter 4202 and Chapter 12 of this title (relating to Independent Review Organizations).

(b) Independent review involving life-threatening and non life-threatening conditions. A URA, or insurance carrier that made the adverse determination, must notify TDI within one working day from the date a request for an independent review is received. The URA, or insurance carrier that made the adverse determination, must submit the completed request for a review by an IRO form to TDI through TDI's Internet website.

(1) Assignment of IRO. Within one working day of receipt of a complete request for independent review, TDI will randomly assign an IRO to conduct the independent review and notify the URA, the payor, the IRO, the injured employee or the injured employee's representative, injured employee's provider of record and any other providers listed by the URA as having records relevant to the review of the assignment.

(2) Workers' compensation non-network coverage. Additional requirements for independent review of an adverse determination for a workers' compensation non-network coverage review are governed by the Texas Workers' Compensation Act and TDI-DWC rules, including but not limited to Chapter 133, Subchapter D, of this title (relating to Dispute of Medical Bills).

(3) Workers' compensation network coverage. Additional requirements for independent review of an adverse determination for a workers' compensation network coverage review are governed by Insurance Code Chapter 1305, TDI rules, and TDI-DWC rules, including but not limited to Chapter 10, Subchapter F, of this title (relating to Utilization Review and Retrospective Review) and Chapter 133, Subchapter D, of this title.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 31, 2013.

TRD-201300376
Sara Waitt
General Counsel
Texas Department of Insurance
Effective date: February 20, 2013
Proposal publication date: August 24, 2012
For further information, please call: (512) 463-6327

♦ ♦ ♦

TITLE 30. ENVIRONMENTAL QUALITY

PART 1. TEXAS COMMISSION ON ENVIRONMENTAL QUALITY

CHAPTER 305. CONSOLIDATED PERMITS

The Texas Commission on Environmental Quality (TCEQ, agency, or commission) adopts the amendments to §§305.50, 305.64, 305.69, 305.122; and new §305.176.

Amended §§305.50, 305.64, 305.69, 305.122, and new 305.176 are adopted *without changes* to the proposed text as published in the October 5, 2012, issue of the *Texas Register* (37 TexReg 7871), and therefore will not be republished.

Background and Summary of the Factual Basis for the Adopted Rules

The federal hazardous waste program is authorized under the Resource Conservation and Recovery Act of 1976 (RCRA), §3006. States may obtain authorization from the United States Environmental Protection Agency (EPA) to administer the hazardous waste program at the state level. State authorization is a rulemaking process through which EPA delegates the primary responsibility of implementing the RCRA hazardous waste program to individual states in lieu of EPA. This process ensures national consistency and minimum standards while providing flexibility to states in implementing rules. State RCRA programs must always be at least as stringent as the federal requirements.

Since the beginning of the federal hazardous waste program, the State of Texas has continuously participated in the EPA's authorization program. To maintain RCRA authorization, the commission must adopt regulations to meet the minimum standards of federal programs administered by EPA. Because the federal regulations undergo regular revision, the commission adopts new regulations periodically to meet the changing federal regulations.

Texas received authorization of its hazardous waste "base program" under the RCRA on December 26, 1984. Texas received authorization for revisions to its base hazardous waste program on February 17, 1987 (Clusters I and II). Texas submitted further revisions to its hazardous waste program and received final authorization of those revisions on March 15, 1990, July 23, 1990, October 21, 1991, December 4, 1992, June 27, 1994, November 26, 1997, October 18, 1999, September 11, 2000, June 14, 2005 (Clusters III - X), March 5, 2009 (Clusters XI - XV), and May 7, 2012 (Clusters IX and XV - XVIII).

The commission adopts in this rulemaking parts of RCRA Rule Clusters XIX - XXI that implement revisions to the federal hazardous waste program, which were made by EPA between July 1, 2008 and June 30, 2011. Both mandatory and optional federal rule changes in these clusters are adopted. Adoption of one of the federal rule changes is mandatory in order to maintain RCRA authorization. Although not necessary in order to maintain authorization, EPA also recommends that the optional federal rule changes be incorporated into the state rules. In addition, the commission adopts revisions to parts of previously adopted Clusters XIV - XVII that implement revisions requested by EPA to maintain authorization. Establishing equivalency with federal regulations will enable the State of Texas to operate all aspects of the federal hazardous waste program in lieu of the EPA.

The commission also adopts revisions to Chapter 305 to clarify requirements for financial capability reviews in conjunction with permit issuances, amendments, transfers, extensions, and renewals for hazardous waste management facilities and also to revise the timing of financial assurance submittals by new owners in conjunction with permit transfers for hazardous waste management facilities.

All adopted rule changes are discussed further in the Section by Section Discussion portion of this preamble. Two corresponding rulemakings are published in this issue of the *Texas Register* and include changes to 30 TAC Chapter 335, Industrial Solid Waste and Municipal Hazardous Waste and 30 TAC Chapter 324, Used Oil Standards.

Section by Section Discussion

The commission adopts administrative changes throughout the rulemaking to reflect the agency's current practices and to conform to *Texas Register* and agency guidelines. These adopted changes include correcting typographical, spelling, and grammatical errors.

§305.50, Additional Requirements for an Application for a Hazardous or Industrial Solid Waste Permit and for a Post-Closure Order

The commission adopts an amendment to §305.50, by reorganizing existing requirements for financial assurance in subsection (a)(4)(B) - (D) into subsection (a)(4)(B). The reorganization will make it easier to understand the information requirements for financial capability reviews. Existing subparagraphs (E) - (G) are relettered to reflect the elimination of subparagraphs (C) and (D).

§305.64, Transfer of Permits

The commission adopts an amendment to §305.64(g), to require new owners and operators of hazardous waste management facilities to provide acceptable financial assurance before the date that a permit modification is issued authorizing the transfer of the permit to the new owner or operator. This change is adopted to reduce the potential for the State of Texas to have to take on the obligation to pay for proper closure, post-closure or corrective action for a site lacking financial assurance. Existing rules require a new permittee to provide financial assurance within six months of a change in ownership or operational control with the previous owner maintaining financial assurance until the new permittee does so. This requirement does not change. An additional requirement is added that the new owner or operator must provide acceptable financial assurance before the modification transferring the permit will be issued. Collectability under certain financial assurance mechanisms is not assured once a permit has been transferred. For example, insurance companies have claimed that a transferor has no insurable interest once a facility has been sold and the permit transferred. In addition, prior owners of hazardous waste management facilities sometimes rely on TCEQ to aggressively pursue recalcitrant new owners to provide financial assurance in order to obtain release of the old owner's

financial assurance mechanism rather than establishing a remedy in the sales contract.

This adopted change will make the timing requirements regarding new financial assurance for hazardous waste management facilities more consistent with other programs at TCEQ. For instance, financial assurance for underground injection control (UIC) wells must be provided by the date of the permit transfer. Since many underground injection control wells are owned in combination with hazardous waste management facilities, transfer of a portion of the financial assurance is already provided by the date of the permit transfer. In addition, language is being revised to clarify that the previous owner or operator must submit a request to the executive director in order for the executive director to allow termination of the financial assurance mechanism.

§305.69, Solid Waste Permit Modification at the Request of the Permittee

The commission adopts an amendment to §305.69(d)(2) to correct the reference to the title of 30 TAC §39.11 to *Text of Public Notice.*

The commission also adopts §305.69(d)(7) to clarify that the notice requirements of §305.69 do not apply to industrial or hazardous waste facility permits that are declared administratively complete on or after September 1, 1999.

In addition, the commission adopts an amendment to §305.69(k), Appendix I (C)(6) to correct a reference from §335.164(10) to §335.164(8). Due to renumbering of §335.164 in a previous rulemaking, the correct citation is §335.164(8).

Furthermore, the commission adopts an amendment to §305.69(k), Appendix I (C)(7)(b) to correct a reference from §335.165(11) to §335.165(13). Due to renumbering of §335.165 in a previous rulemaking, the correct citation is §335.165(13).

The commission adopts an amendment to §305.69(k), Appendix I (C)(8)(a) to correct a reference from §335.165(9)(B) to §335.165(11)(B). Due to renumbering of §335.165 in a previous rulemaking, the correct citation should be §335.165(11)(B).

§305.122, Characteristics of Permits

The commission adopts §305.122(b) to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). The amendment will reinstate a missing sentence which was inadvertently omitted by EPA. The adopted rule will allow certain changes to permits for cause, such as, modification, revocation and reissuance, or termination. It will also allow modification to a permit upon request of a permittee. Such changes must be consistent with applicable federal regulations. The paragraph and subparagraphs in the subsection have been renumbered and relettered accordingly. This amendment is recommended by EPA to be adopted into state rules, but is not required to maintain RCRA authorization.

§305.176, Integration with Maximum Achievable Control Technology (MACT) Standards

The commission adopts new §305.176 to increase the options to integrate air quality standards into a RCRA hazardous waste permit. The new language will conform to federal regulations previously promulgated in the October 12, 2005, issue of the *Federal Register* (70 FR 59402). The adopted new section does not set or impose any new air quality standards. The Hazardous Waste Combustion MACT regulations are multi-media regulations at the federal and state level, affecting both air quality and hazardous waste management. The TCEQ has already adopted certain parts of 40 Code of Federal Regulations (CFR) Part 63, Subpart EEE (i.e., the Hazardous Waste Combustion MACT rules) prior to this rulemaking under Chapter 305 and air quality regulations at 30 TAC Chapter 113, Standards of Performance for Hazardous Air Pollutants and for Designated Facilities and Pollutants. This rulemaking will incorporate integration options with MACT standards for hazardous waste incinerators in Chapter 305, Subchapter I. In a previous rulemaking, an amendment regarding the integration options with MACT standards was adopted into §305.572 for boilers and industrial furnaces. Conforming language is adopted in §305.176 to adopt by reference 40 CFR §270.235, Options for Incinerators, Cement Kilns, Lightweight Aggregate Kilns, Solid Fuel Boilers, Liquid Fuel Boilers and Hydrochloric Acid Production Furnaces to Minimize Emissions from Startup, Shutdown, and Malfunction Events. The addition of §305.176 will provide greater flexibility by allowing operators of incinerators the same integration options with MACT standards as operators of boilers and industrial furnaces in §305.572.

Final Regulatory Impact Determination

The commission reviewed the rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking is not subject to Texas Government Code, §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in that statute. Although the intent of the rulemaking is to protect the environment and reduce the risk to human health from environmental exposure, the rulemaking is not a major environmental rule because it will not adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. There is no adverse effect in a material way on the economy, a sector of the economy, productivity, competition, or jobs of the state or a sector of the state from those revisions under 42 United States Code (USC), §6926(g), which already imposes the more stringent federal requirements on the regulated community under the Hazardous and Solid Waste Amendments of 1984. Likewise, there is no adverse effect in a material way on the economy, a sector of the economy, productivity, competition, or jobs of the state or a sector of the state from those revisions outside 42 USC, §6926(g), because either the changes are not substantive, the changes move forward compliance with financial assurance requirements without changing those requirements, or the regulated community benefits from the greater flexibility and reduced compliance burden. The regulated community must comply with the more stringent federal requirements beginning on the effective date of the federal regulations. Because the regulated community is already required to comply with the more stringent federal rules, equivalent state rules will not cause any adverse effects. There is no adverse effect in a material way on the environment, or the public health and safety of the state or a sector of the state because the rulemaking is designed to protect the environment, the public health, and the public safety of the state and all sectors of the state. Because the rulemaking does not have an adverse material impact on the economy, the rulemaking does not meet the definition of a major environmental rule. Furthermore, the rulemaking does not meet any of the four applicability requirements listed in Texas Government Code, §2001.0225(a). First, the rulemaking does not exceed a standard set by federal law. The commission must meet the minimum standards and mandatory requirements of the federal program to maintain

authorization of the state hazardous waste program. The other changes do not alter substantive requirements although various changes may increase flexibility for the regulated community and move forward compliance deadlines. Second, although the rulemaking contains some requirements that are more stringent than existing state rules, federal law requires the commission to promulgate rules that are as stringent as federal law for the commission to maintain authorization of the state hazardous waste program. Third, the rulemaking does not exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government, where the delegation agreement or contract is to implement a state and federal program. On the contrary, the commission must undertake the waste program. And fourth, the rulemaking does not seek to adopt a rule solely under the general powers of the agency instead of under a specific state law. The commission adopts this rulemaking under Texas Water Code, §5.103 and §5.105 and under Texas Health and Safety Code, §361.017 and §361.024.

The commission invited public comment regarding the draft regulatory impact analysis determination during the public comment period, but received no comments relating to this subject.

Takings Impact Assessment

The commission evaluated the rulemaking and performed an assessment of whether Texas Government Code, Chapter 2007 applies. The commission's assessment indicates that Texas Government Code, Chapter 2007 does not apply to the rulemaking because this action is reasonably taken to fulfill an obligation mandated by federal law; therefore, this action is exempt under Texas Government Code, §2007.003(b)(4). The specific purpose of the rulemaking is to maintain state RCRA authorization by adopting state hazardous waste rules that are equivalent to the federal regulations. The rulemaking substantially advances this purpose by adopting rules that incorporate and refer to the federal regulations. Promulgation and enforcement of the rules is not a statutory or constitutional taking of private real property. Specifically, the rulemaking does not affect a landowner's rights in private real property because this rulemaking does not constitutionally burden the owner's right to property, does not restrict or limit the owner's right to property, and does not reduce the value of property by 25% or more beyond that which would otherwise exist in the absence of the regulations. The rulemaking seeks to meet the minimum standards of federal RCRA regulations that are already in place. 42 USC, §6926(g) imposes on the regulated community any federal requirements that are more stringent than current state rules. The regulated community must already have complied with the more stringent federal requirements as of the effective date of the federal regulations. Because the regulated community is already required to comply with the more stringent federal regulations, promulgating equivalent state rules does not burden, restrict, or limit the owner's right to property and does not reduce the value of property by 25% or more. Likewise, the regulated community is not unduly burdened by those revisions providing greater flexibility, reduced recordkeeping, reporting, inspection, and sampling requirements.

Consistency with the Coastal Management Program

The commission reviewed the rulemaking and found that the rulemaking is subject to the Texas Coastal Management Program (CMP) in accordance with the Coastal Coordination Act, Texas Natural Resources Code, §§33.201 *et seq.,* and therefore must be consistent with all applicable CMP goals and policies. The commission conducted a consistency determination for the adopted rules in accordance with Coastal Coordination Act Implementation Rules, 31 TAC §505.22 and found the rulemaking is consistent with the applicable CMP goals and policies. The CMP goal applicable to the rulemaking is to protect, preserve, restore, and enhance the diversity, quality, quantity, functions, and values of coastal natural resource areas (CNRAs). Applicable policies are construction and operation of solid waste treatment, storage, and disposal facilities, such that new solid waste facilities and areal expansions of existing solid waste facilities shall be sited, designed, constructed, and operated to prevent releases of pollutants that may adversely affect CNRAs and, at a minimum, comply with standards established under the Solid Waste Disposal Act, 42 USC, §§6901 *et seq.* Promulgation and enforcement of these rules are consistent with the applicable CMP goals and policies because the adopted rulemaking will update and enhance the commission's rules concerning hazardous waste facilities. In addition, the rules will not violate any applicable provisions of the CMP's stated goals and policies.

The commission invited public comment regarding the consistency of this rulemaking with the CMP during the public comment period, but received no comments relating to this subject.

Public Comment

The comment period closed on November 5, 2012. No comments were received.

SUBCHAPTER C. APPLICATION FOR PERMIT OR POST-CLOSURE ORDER

30 TAC §305.50

Statutory Authority

The amendment is adopted under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste), THSC, §361.085 (relating to Financial Assurance and Disclosure by Permit Applicant), and THSC, §361.024 (relating to Rules and Standards) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The adopted amendment implements THSC, Chapter 361.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300393
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: February 21, 2013
Proposal publication date: October 5, 2012
For further information, please call: (512) 239-0779

♦ ♦ ♦

SUBCHAPTER D. AMENDMENTS, RENEWALS, TRANSFERS, CORRECTIONS, REVOCATION, AND SUSPENSION OF PERMITS

30 TAC §305.64, §305.69

Statutory Authority

The amendments are adopted under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste), THSC, §361.085 (relating to Financial Assurance and Disclosure by Permit Applicant), and THSC, §361.024 (relating to Rules and Standards) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The adopted amendments implement THSC, Chapter 361.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300394
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: February 21, 2013
Proposal publication date: October 5, 2012
For further information, please call: (512) 239-0779

♦ ♦ ♦

SUBCHAPTER F. PERMIT CHARACTERISTICS AND CONDITIONS

30 TAC §305.122

Statutory Authority

The amendment is adopted under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste), THSC, §361.085 (relating to Financial Assurance and Disclosure by Permit Applicant), and THSC, §361.024 (relating to Rules and Standards) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The adopted amendment implements THSC, Chapter 361.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300395
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: February 21, 2013
Proposal publication date: October 5, 2012
For further information, please call: (512) 239-0779

♦ ♦ ♦

SUBCHAPTER I. HAZARDOUS WASTE INCINERATOR PERMITS

30 TAC §305.176

Statutory Authority

The new section is adopted under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste), THSC, §361.085 (relating to Financial Assurance and Disclosure by Permit Applicant), and THSC, §361.024 (relating to Rules and Standards) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The adopted new section implements THSC, Chapter 361.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300396
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: February 21, 2013
Proposal publication date: October 5, 2012
For further information, please call: (512) 239-0779

♦ ♦ ♦

CHAPTER 324. USED OIL STANDARDS

SUBCHAPTER A. USED OIL RECYCLING

The Texas Commission on Environmental Quality (TCEQ, agency, or commission) adopts the amendments to §§324.1 - 324.4, 324.6, 324.7, and 324.11 - 324.16; and repeals §324.5.

Amended §§324.1 - 324.4, 324.6, 324.7, and 324.11 - 324.16 and the repeal of §324.5 are adopted *without changes* to the proposed text as published in the October 5, 2012, issue of the

Texas Register (37 TexReg 7887) and therefore will not be republished.

Background and Summary of the Factual Basis for the Adopted Rules

The federal used oil recycling program is authorized under the Used Oil Recycling Act of 1980, Resource Conservation and Recovery Act of 1976 (RCRA), §3014. The United States Environmental Protection Agency (EPA) sets standards for used oil destined for recycling to prevent mismanagement by generators, collection centers, transporters, processors and re-refiners, burners, and marketers. Those federal standards are located in 40 Code of Federal Regulations (CFR) Part 279.

States may obtain authorization from the EPA to administer the used oil recycling program at the state level. State authorization is a rulemaking process through which EPA delegates the primary responsibility of implementing the RCRA used oil recycling program to individual states in lieu of EPA. This process ensures national consistency and minimum standards while providing flexibility to states in implementing rules. State RCRA programs must always be at least as stringent as the federal requirements.

Since the beginning of the federal used oil recycling program, the State of Texas has continuously participated in the EPA's authorization program. To maintain RCRA authorization, the commission must adopt regulations to meet the minimum standards of federal programs administered by EPA. Because the federal regulations undergo regular revision, the commission must adopt new regulations periodically to meet the changing federal regulations.

The commission adopts in this rulemaking revisions to the federal used oil recycling program that were previously adopted by EPA in parts of Clusters XIV - XVII. Establishing equivalency with federal regulations will enable the State of Texas to operate all aspects of the federal used oil recycling program in lieu of the EPA.

All adopted rule changes are further discussed in the Section by Section Discussion portion of this preamble. Two corresponding rulemakings are published in this issue of the *Texas Register* and include changes to 30 TAC Chapter 305, Consolidated Permits, and 30 TAC Chapter 335, Industrial Solid Waste and Municipal Hazardous Waste.

Section by Section Discussion

The commission adopts administrative changes throughout the rulemaking to reflect the agency's current practices and to conform to *Texas Register* and agency guidelines. These adopted changes include correcting typographical, spelling, and grammatical errors throughout the chapter and also incorporating by reference the typographical, spelling, and grammatical corrections in 40 CFR Part 279. In addition, the commission replaces the phrases "shall be as" and "will be as" with the phrase, "The commission incorporates by reference." This change in phrasing will avoid any ambiguity as to the commission's action to incorporate the federal used oil rules. Finally, the commission adopts substantive changes throughout the chapter such as: removing the requirement to use SW-846 as the testing method to ensure that used oil does not contain significant concentrations of halogenated hazardous constituents, adding clarifying language regarding used oil containing polychlorinated biphenyls (PCBs), and revising tracking requirements for used oil marketers. The changes will make it easier for recyclers to comply with the RCRA regulations.

§324.1, Federal Rule Adoption by Reference

The commission adopts §324.1 to incorporate by reference the federal regulations promulgated in the July 14, 2006, issue of the *Federal Register* (71 FR 40280). Specifically, this amendment will update the "amended through" date to "July 14, 2006 at 71 FedReg 40280." An introductory sentence is added to make clear that recyclers in Texas must comply with federal used oil regulations and with any additional requirements specified in Chapter 324. The terms "Administrator or Regional Administrator," "Environmental Protection Agency (EPA)," and "Commission" are moved to this section from the definition section in §324.2.

§324.2, Definitions

The commission adopts amended §324.2. First, the commission amends §324.2 to incorporate by reference the federal regulations promulgated in the July 14, 2006, issue of the *Federal Register* (71 FR 40280). Specifically, this amendment will correct the spelling of the word "kerosine" to "kerosene" in the definition for "Petroleum refining facility" found in 40 CFR §279.1. Second, the commission amends §324.2(5), renumbered to §324.2(3), to replace the word "Recycling" with the phrase "Recycling of used oil." This change will clarify that this definition pertains to used oil. Third, the commission adds language to §324.2(7), renumbered to §324.2(5), to revise the definition of "Secondary containment" to add the clause "shall be designed to meet the specifications found in §324.22(d)(3) to retain." This language is integral to the state's program requirements regarding secondary containment for used oil. Fourth, the definitions for "Administrator or Regional Administrator" found in §324.2(2), "Commission" found in §324.2(3), and "Environmental Protection Agency (EPA)" found in §324.2(4) are removed. The terms, "Administrator or Regional Administrator," "Environmental Protection Agency (EPA)," and "Commission" are moved to §324.1 as part of the Federal Rule Adoption by Reference section. The definitions in §324.2 have been alphabetized and renumbered accordingly. Fifth, the introductory phrase "Most words are as defined" is changed to "The commission incorporates by reference the definitions" to make clear that all definitions in 40 CFR §279.1 are part of the state regulations and enforceable. Furthermore, the commission adopts certain additional definitions as part of §324.2.

§324.3, Applicability

The commission adopts amended §324.3. First, the commission amends §324.3 to adopt by reference the regulations promulgated in the July 30, 2003, issue of the *Federal Register* (68 FR 44665). This amendment will add revised language in 40 CFR §279.10(i) relating to Used Oil Containing PCBs. Specifically, this amendment will clarify when used oil contaminated with PCBs is regulated under the RCRA used oil management standards and when it is not. Second, the commission adopts an amendment to §324.3 to adopt by reference the regulations promulgated in the June 14, 2005, issue of the *Federal Register* (70 FR 34591). This amendment will remove the requirement in 40 CFR §279.10(b)(1)(ii) relating to Applicability, to use SW-846 as the testing method. This change will ensure that the used oil does not contain significant concentrations of halogenated hazardous constituents and will make it easier for recyclers to comply with the RCRA regulations by allowing more flexibility in method selection and use. Third, the commission amends §324.3 to adopt by reference the regulations promul-

gated in the July 14, 2006, issue of the *Federal Register* (71 FR 40280). This amendment will make grammatical corrections to 40 CFR §279.10(b)(2) relating to Applicability, and will change the language in 40 CFR §279.11 relating to Used Oil Specifications. Fourth, the commission amends §324.3 by adding the phrases "The commission incorporates by reference" and "In addition, the commission adds the following clarifications and requirements:", and removing the phrases "applicability will be as" and "and as clarified here." These revisions will avoid any ambiguity as to the commission's action to incorporate the federal used oil rules and to clarify that there are additional state requirements. Fifth, the commission adopts language added to §324.3(5) which reads "and meet the prohibition requirements found in §324.4 of this title (relating to Prohibitions) to prevent the discharge of hazardous waste into a sanitary sewer." This amendment will clarify that the State of Texas is not allowing the discharge of hazardous waste into a sanitary sewer.

§324.4, Prohibitions

The commission adopts §324.4 by adding the phrases "The commission incorporates by reference the" and "In addition, the commission requires the following:" and removing the phrases "will be as" and "and as specified here." These changes in phrasing will avoid any ambiguity as to the commission's action to incorporate the federal used oil rules and to clarify that there are additional state requirements.

§324.5, Notice by Retail Dealer

The commission adopts the repeal of §324.5 and adds the statement concerning where to obtain a sign to §324.7(1)(A) and (3)(A). The adopted repeal allows the regulated community to find the contact address in the same section where the requirement for signs is placed.

§324.6, Generators

The commission adopts §324.6 to replace the phrase "shall be as" with the phrase "The commission incorporates by reference." This change in phrasing will avoid any ambiguity as to the commission's action to incorporate the federal used oil rules.

§324.7, Collection Centers

The commission adopts amended §324.7. First, the commission amends §324.7 to replace the phrases "Rules for" and "shall be as" with the phrase "The commission incorporates by reference rules for owners or operators of all" in front of the phrase "do-it-yourselfer (DIY) used oil collection centers." This change in phrasing will avoid any ambiguity as to the commission's action to incorporate the federal used oil rules, is consistent with the federal rules and clarifies that the section applies to the owners or operators of these facilities. Second, the commission removes the phrase "and as specified here" and adds the phrase "In addition, the commission requires the following:". This adopted change clarifies that there are additional state requirements that must be followed by collection centers. Third, the commission also amends §324.7(1)(A) and (3)(A) to add the statement concerning where to obtain a sign. This adopted change will organize all the information on obtaining a sign in one place. The regulated community will no longer have to refer to §324.5 to determine how to obtain a sign that is required to be posted per §324.7(1)(A) and (3)(A). Fourth, the commission also amends §324.7(1)(B) and (3)(B) to remove the mailing address because it is provided on commission cover letters and forms and to update the agency name from Texas Natural Resource Conservation Commission to Texas Commission on Environmental Quality.

§324.11, Transporters and Transfer Facilities

The commission adopts amended §324.11. First, the commission amends §324.11 by adding the phrase "The commission incorporates by reference" and removing the words "are" and ", and in this section" and adding the phrase "In addition, the commission requires the following: " These changes will avoid any ambiguity as to the commission's actions to incorporate the federal used oil rules and clarify that there are additional state requirements. Second, the commission adopts by reference the federal regulations promulgated in the June 14, 2005, issue of the *Federal Register* (70 FR 34591). This amendment will remove the requirement to use SW-846 as the testing method in 40 CFR §279.44(c) relating to Rebuttable Presumption for Used Oil. This amendment will ensure that the used oil does not contain significant concentrations of halogenated hazardous constituents and will make it easier for recyclers to comply with the RCRA regulations by allowing more flexibility in method selection and use. Third, the commission amends §324.11 to adopt by reference the regulations promulgated in the July 14, 2006, issue of the *Federal Register* (71 FR 40280). This amendment will make grammatical corrections in 40 CFR §279.43(c)(3)(i) and (5) relating to Used Oil Transportation, 40 CFR §279.44(a) and (c)(2) relating to Rebuttable Presumption for Used Oil, and 40 CFR §279.45(a) relating to Used Oil Storage at Transfer Facilities. Fourth, the commission amends §324.11(2) to update the agency name from Texas Natural Resource Conservation Commission to Texas Commission on Environmental Quality and to remove the mailing address because it is provided on commission cover letters and forms.

§324.12, Processors and Re-refiners

The commission adopts amended §324.12. First, the commission amends §324.12 by adding the phrases "The commission incorporates by reference," "owners and operators of" and "In addition, the commission requires the following:". These additions will require changing the tense of the words "processors" and "re-refiners" to "processing" and "re-refining," and removing the words "are" and "and in this section." These changes will avoid any ambiguity as to the commission's actions to incorporate the federal used oil rules, clarify that the section applies to the owners and operators of these facilities and clarify that there are additional state requirements. Second, the commission amends §324.12(2) and (4) to remove the mailing address because it is provided on commission instruction letters and forms. Third, the commission amends §324.12 to update the agency name from Texas Natural Resource Conservation Commission to Texas Commission on Environmental Quality. Fourth, the commission adopts by reference the federal regulations promulgated in the June 14, 2005, issue of the *Federal Register* (70 FR 34591). This amendment will remove the requirement to use SW-846 as the testing method in 40 CFR §279.53(c) relating to Rebuttable Presumption for Used Oil. This amendment will ensure that the used oil does not contain significant concentrations of halogenated hazardous constituents and makes it easier for recyclers to comply with the RCRA regulations by allowing more flexibility in method selection and use. Fifth, the commission amends §324.12 to adopt by reference the federal regulations promulgated in the July 14, 2006, issue of the *Federal Register* (71 FR 40280). This amendment will make grammatical corrections in 40 CFR §279.52(a) - (b), (b)(1)(ii), (6)(ii) and (iii) relating to General Facility Standards; 40 CFR §279.54(g) relating to

Used Oil Management; 40 CFR §279.55(a) and (b)(2)(i)(B) relating to Analysis plan; 40 CFR §279.56(a)(2) relating to Tracking; 40 CFR §279.57(a)(2)(ii) relating to Operating record and reporting; and 40 CFR §279.59 relating to the Management of residues.

Additionally, the commission amends the title of §324.12 from "Processors and Rerefiners" to "Processors and Re-refiners".

§324.13, Burners of Off-specification Used Oil for Energy Recovery

The commission adopts amended §324.13. First, the commission amends §324.13 by adding the phrase "The commission incorporates by reference" and removing the word "are." This change in phrasing will avoid any ambiguity as to the commission's action to incorporate the federal used oil rules. Second, the commission adds the phrase "In addition, the commission requires the following:" and removes the phrase ", and in this section." This change will clarify that there are additional state requirements. Third, the commission amends §324.13(2) to remove the mailing address for the agency because it is provided on commission cover letters and forms and to update the agency name from Texas Natural Resource Conservation Commission to Texas Commission on Environmental Quality. Fourth, the commission adopts by reference the federal regulations promulgated in the June 14, 2005, issue of the *Federal Register* (70 FR 34591). This amendment will remove the requirement to use SW-846 as the testing method in 40 CFR §279.63(c) relating to Rebuttable Presumption for Used Oil. This amendment will ensure that the used oil does not contain significant concentrations of halogenated hazardous constituents and makes it easier for recyclers to comply with the RCRA regulations by allowing more flexibility in method selection and use. Fifth, the commission amends §324.13 to adopt by reference the regulations promulgated in the July 14, 2006, issue of the *Federal Register* (71 FR 40280). This adopted amendment will make grammatical corrections in 40 CFR §279.63(b)(3) relating to Rebuttable Presumption for Used Oil and 40 CFR §279.64(e) relating to Used Oil Storage.

§324.14, Marketers of Used Oil Fuel

The commission adopts amended §324.14. First, the commission amends §324.14 by adding the phrases "The commission incorporates by reference," "These rules," "In addition" and the word "found" and removing the phrase "and this section." These changes will avoid any ambiguity as to the commission's action to incorporate the federal used oil rules and make the sentence more readable. Second, the commission amends §324.14 to remove the mailing address because it is provided on commission cover letters and forms. Third, the commission amends §324.14 to update the agency name from Texas Natural Resource Conservation Commission to Texas Commission on Environmental Quality. Fourth, the commission adopts by reference the federal regulations promulgated in the July 30, 2003, issue of the *Federal Register* (68 FR 44665). This amendment will revise the language in 40 CFR §279.74(b) relating to Tracking. Specifically, the amendment will allow the initial marketer of used oil that meets the used oil fuel specifications in 40 CFR §279.11 to only keep a record of a shipment of used oil to the facility to which the initial marketer delivers the used oil. Fifth, the commission amends §324.14 to adopt by reference the regulations promulgated in the July 14, 2006, issue of the *Federal Register* (71 FR 40280). This amendment will make grammatical corrections in 40 CFR §279.70(b)(1) relating to Applicability.

§324.15, Spills

The commission adopts amended §324.15 by adding the phrase "The commission incorporates by reference" and removing the word "See." This revision will avoid any ambiguity as to the commission's action to incorporate the federal used oil rules. The commission also adopts additional language which will require recyclers to immediately clean up spills that meet the reportable quantity limit. Specifically, the amendment will incorporate federal requirements found in 40 CFR §§279.22(d), 279.43(c), 279.45(h), 279.54(g), and 279.64 regarding Reporting and Managing Spills. The section will continue to require used oil recyclers to comply with 30 TAC Chapter 327 relating to Spill Prevention and Control.

§324.16, Polychlorinated Biphenyls (PCBs)

The commission adopts amended §324.16 by adding the phrase "The commission incorporates by reference" and removing the phrase "shall be as," and restructuring the sentence to make it easier to read. These changes will avoid any ambiguity as to the commission's action to incorporate the federal used oil rules.

Final Regulatory Impact Determination

The commission reviewed the adopted rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking is not subject to Texas Government Code, §2001.0225, because it does not meet the definition of a "major environmental rule" as defined in that statute. Although the intent of the rulemaking is to protect the environment and reduce the risk to human health from environmental exposure, the rulemaking is not a major environmental rule because it will not adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. There is no adverse effect in a material way on the economy, a sector of the economy, productivity, competition, or jobs of the state or a sector of the state from those revisions under 42 United States Code (USC), §6926(g), which already imposes the more stringent federal requirements on the regulated community under the Hazardous and Solid Waste Amendments of 1984. Likewise, there is no adverse effect in a material way on the economy, a sector of the economy, productivity, competition, or jobs of the state or a sector of the state from those revisions outside 42 USC, §6926(g), because either the changes are not substantive, or the regulated community benefits from the greater flexibility and reduced compliance burden. The regulated community must comply with the more stringent federal requirements beginning on the effective date of the federal regulations. Because the regulated community is already required to comply with the more stringent federal rules, equivalent state rules will not cause any adverse effects. There is no adverse effect in a material way on the environment, or the public health and safety of the state or a sector of the state because the rulemaking is designed to protect the environment, the public health, and the public safety of the state and all sectors of the state. Because the rulemaking does not have an adverse material impact on the economy, the rulemaking does not meet the definition of a major environmental rule. Furthermore, the rulemaking does not meet any of the four applicability requirements listed in Texas Government Code, §2001.0225(a). First, the rulemaking does not exceed a standard set by federal law because the commission adopts this rulemaking to implement revisions to the federal hazardous waste program. The commission must meet the minimum standards and mandatory requirements of the federal program to maintain authorization of the state hazardous waste

program. The other changes do not alter substantive requirements although various changes may increase flexibility for the regulated community and move forward compliance deadlines. Second, although the rulemaking contains some requirements that are more stringent than existing state rules, federal law requires the commission to promulgate rules that are as stringent as federal law for the commission to maintain authorization of the state hazardous waste program. Third, the rulemaking does not exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government, where the delegation agreement or contract is to implement a state and federal program. On the contrary, the commission must undertake the waste program. And fourth, the rulemaking does not seek to adopt a rule solely under the general powers of the agency instead of under a specific state law. The commission adopts this rulemaking under Texas Water Code, §5.103 and §5.105 and under Texas Health and Safety Code, §361.017 and §361.024.

The commission invited public comment regarding the draft regulatory impact analysis determination during the public comment period, but received no comments relating to this subject.

Takings Impact Assessment

The commission evaluated the rulemaking and performed an assessment of whether Texas Government Code, Chapter 2007 applies. The commission's assessment indicates that Texas Government Code, Chapter 2007 does not apply to the rulemaking because this action is reasonably taken to fulfill an obligation mandated by federal law; therefore, this action is exempt under Texas Government Code, §2007.003(b)(4). The specific purpose of the rulemaking is to maintain state RCRA authorization by adopting state hazardous waste rules that are equivalent to the federal regulations. The rulemaking substantially advances this purpose by adopting rules that incorporate and refer to the federal regulations. Promulgation and enforcement of the rules is not a statutory or constitutional taking of private real property. Specifically, the rulemaking does not affect a landowner's rights in private real property because this rulemaking does not constitutionally burden the owner's right to property, does not restrict or limit the owner's right to property, and does not reduce the value of property by 25% or more beyond that which would otherwise exist in the absence of the regulations. The rulemaking seeks to meet the minimum standards of federal RCRA regulations that are already in place. 42 USC, §6926(g) imposes on the regulated community any federal requirements that are more stringent than current state rules. The regulated community must already have complied with the more stringent federal requirements as of the effective date of the federal regulations. Because the regulated community is already required to comply with the more stringent federal regulations, promulgating equivalent state rules does not burden, restrict, or limit the owner's right to property and does not reduce the value of property by 25% or more. Likewise, the regulated community is not unduly burdened by those revisions providing greater flexibility, reduced recordkeeping, reporting, inspection, and sampling requirements.

Consistency with the Coastal Management Program

The commission reviewed the adopted rules and found that they are neither identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11(b)(2) or (4), nor will they affect any action/authorization identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11(a)(6). Therefore, the adopted rules are not subject to the Texas Coastal Management Program.

Public Comment

The comment period closed on November 5, 2012. No comments were received.

30 TAC §§324.1 - 324.4, 324.6, 324.7, 324.11 - 324.16

Statutory Authority

The amendments are adopted under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §371.026 (relating to Registration and Reporting Requirements of Used Oil Handlers, Other than Generators) and THSC, §371.028 (relating to Rules) which authorize the commission to regulate used oil handlers, to implement the used oil recycling program established by THSC, Chapter 371, and to adopt rules consistent with the general intent and purposes of the THSC.

The adopted amendments implement THSC, Chapter 371.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300397
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: February 21, 2013
Proposal publication date: October 5, 2012
For further information, please call: (512) 239-0779

♦ ♦ ♦

30 TAC §324.5

Statutory Authority

The repeal is adopted under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §371.026 (relating to Registration and Reporting Requirements of Used Oil Handlers, Other than Generators) and THSC, §361.028 (relating to Rules) which authorize the commission to regulate used oil handlers, to implement the used oil recycling program established by THSC, Chapter 371, and to adopt rules consistent with the general intent and purposes of the THSC.

The adopted repeal implements THSC, Chapter 371.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300398

Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: February 21, 2013
Proposal publication date: October 5, 2012
For further information, please call: (512) 239-0779

♦ ♦ ♦

CHAPTER 335. INDUSTRIAL SOLID WASTE AND MUNICIPAL HAZARDOUS WASTE

The Texas Commission on Environmental Quality (TCEQ, agency, or commission) adopts the amendments to §§335.1, 335.2, 335.10 - 335.13, 335.19, 335.24, 335.61, 335.62, 335.69, 335.76, 335.78, 335.111, 335.112, 335.151, 335.152, 335.155, 335.168, 335.170, 335.213, 335.222, 335.251, 335.431, and 335.504; and new §335.79.

Amended §§335.1, 335.2, 335.10 - 335.13, 335.19, 335.24, 335.61, 335.62, 335.69, 335.76, 335.78, 335.111, 335.112, 335.151, 335.152, 335.155, 335.168, 335.170, 335.213, 335.222, 335.251, 335.431, and 335.504; and new §335.79 are adopted *without changes* to the proposed text as published in the October 5, 2012, issue of the *Texas Register* (37 TexReg 7895) and therefore will not be republished.

Background and Summary of the Factual Basis for the Adopted Rules

The federal hazardous waste program is authorized under the Resource Conservation and Recovery Act of 1976 (RCRA), §3006. States may obtain authorization from the United States Environmental Protection Agency (EPA) to administer the hazardous waste program. State authorization is a rulemaking process through which EPA delegates the primary responsibility of implementing the RCRA hazardous waste program to individual states in lieu of EPA. This process ensures national consistency and minimum standards while providing flexibility to states in implementing rules. State RCRA programs must always be at least as stringent as the federal requirements.

Since the beginning of the federal hazardous waste program, the State of Texas has continuously participated in the EPA's authorization program. To maintain RCRA authorization, the commission must adopt regulations to meet the minimum standards of federal programs administered by EPA. Because the federal regulations undergo regular revision, the commission adopts new regulations regularly to meet the changing federal regulations.

Texas received authorization of its hazardous waste "base program" under the RCRA on December 26, 1984. Texas received authorization for revisions to its base hazardous waste program on February 17, 1987 (Clusters I and II). Texas submitted further revisions to its hazardous waste program and received final authorization of those revisions on March 15, 1990, July 23, 1990, October 21, 1991, December 4, 1992, June 27, 1994, November 26, 1997, October 18, 1999, September 11, 2000, June 14, 2005 (Clusters III - X), March 5, 2009 (Clusters XI - XV), and May 7, 2012 (Clusters IX and XV - XVIII).

The commission adopts in this rulemaking parts of RCRA Rule Clusters XIX - XXI that implement revisions to the federal hazardous waste program which were made by EPA between July 1, 2008 and June 30, 2011. Both mandatory and optional federal rule changes in these clusters are adopted. Adoption of one of the federal rule changes is mandatory in order to maintain RCRA authorization. Although not necessary in order to maintain authorization, EPA also recommends that the optional federal rule changes be incorporated into the state rules. In addition, the commission adopts revisions to parts of previously adopted Clusters XIV - XVII that implement revisions requested by EPA that are needed to maintain authorization. Establishing equivalency with federal regulations will enable the State of Texas to operate all aspects of the federal hazardous waste program in lieu of the EPA.

All adopted rule changes are discussed further in the Section by Section Discussion portion of this preamble. Two corresponding rulemakings are published in this issue of the *Texas Register* and include changes to 30 TAC Chapter 305, Consolidated Permits and 30 TAC Chapter 324, Used Oil Standards.

Section by Section Discussion

The commission adopts administrative changes throughout the rulemaking to reflect the agency's current practices and to conform to *Texas Register* and agency guidelines. These changes include updating references to Texas State Agencies, updating cross-references, and correcting typographical, spelling, and grammatical errors.

§335.1, Definitions

The commission adopts §335.1(39) to conform to federal regulations previously promulgated in the March 4, 2005, issue of the *Federal Register* (70 FR 10776). Specifically, this amendment will revise the definition of "Designated facility" so that it is consistent with the EPA definition in 40 Code of Federal Regulations (CFR) §260.10. Also, the definition is reorganized to separate the definition of a Texas Class 1 waste designated facility from the definition of a hazardous waste designated facility.

The commission adopts §335.1(59)(B) to conform to federal regulations previously promulgated in the September 8, 2005, issue of the *Federal Register* (70 FR 53420). This amendment will clarify the definition of "Facility" for the purpose of implementing corrective action under the authority of a standard permit. Specifically, this amendment will incorporate by reference corrective action authorized by 40 CFR Part 267, Subpart F (Releases from Solid Waste Management Units) to address corrective action under the authority of a standard permit.

The commission adopts §335.1(95) to conform to federal regulations previously promulgated in the March 4, 2005, issue of the *Federal Register* (70 FR 10776). Specifically, this amendment will revise the definition of "Manifest" so that it is consistent with the EPA definition in 40 CFR §260.10.

The commission adopts §335.1(96) to conform to federal regulations previously promulgated in the March 4, 2005, issue of the *Federal Register* (70 FR 10776). Specifically, this amendment will revise the definition of "Manifest tracking number" so that it is consistent with the EPA definition in 40 CFR §260.10.

The commission adopts §335.1(138)(A)(iv) to conform to federal regulations previously promulgated in the July 28, 2006, issue of the *Federal Register* (71 FR 42928). This amendment will add requirements for notification and recordkeeping to exclude cathode ray tubes (CRTs) that meet the requirements in 40 CFR §261.39 and §261.40 for reuse and recycling from classification as a solid waste. This exclusion is also found in 40 CFR §261.4 which was adopted in a previous rulemaking. This amendment will add additional language from 40 CFR Part 261, Subpart E concerning conditional exclusions and notification and recordkeeping requirements for CRTs. In addition, technical correc-

tions are incorporated by reference to conform to federal regulations previously promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989).

The commission also adopts §335.1(142) to conform to federal regulations previously promulgated in the September 8, 2005, issue of the *Federal Register* (70 FR 53420). Specifically, this amendment will revise the definition of "Standard permit" so that it is consistent with the EPA definition in 40 CFR §124.2(a).

§335.2, Permit Required

The commission adopts §335.2(g) to conform to federal regulations previously promulgated in the April 4, 2006, issue of the *Federal Register* (71 FR 16862). Specifically, this amendment will revise the reporting requirements for treatability studies by reducing the amount of information required to be submitted.

§335.10, Shipping and Reporting Procedures Applicable to Generators of Hazardous Waste or Class 1 Waste and Primary Exporters of Hazardous Waste

The commission adopts §335.10 by restructuring to separate Texas Class 1 waste from hazardous waste manifest requirements thereby eliminating confusion between the two programs. The commission incorporates by reference EPA manifest requirements to ensure consistency. Current Class 1 waste manifest requirements are the same as EPA hazardous waste manifest requirements with some minor differences. This rulemaking does not change any of those requirements. The Uniform Hazardous Waste Manifest requirements are incorporated by reference as published in the March 4, 2005, issue of the *Federal Register* (70 FR 10776) and amended through the March 18, 2010, issue of the *Federal Register* (75 FR 12989). These changes will allow generators of hazardous and industrial waste to more readily identify applicable manifest requirements. This adopted amendment will help ensure compliance with manifest requirements including proper completion of the manifest form. Additionally, references to the EPA are changed to the TCEQ and references to the regional director are changed to the executive director.

§335.11, Shipping Requirements for Transporters of Hazardous Waste or Class 1 Waste

The commission adopts §335.11 by restructuring to separate Texas Class 1 waste from hazardous waste manifest requirements thereby eliminating confusion between the two programs. The commission incorporates by reference EPA manifest requirements to ensure consistency. Current Class 1 waste manifest requirements are the same as EPA hazardous waste manifest requirements with some minor differences. This adopted rulemaking will not change any of the manifest requirements. The Uniform Hazardous Waste Manifest requirements are incorporated by reference as published in the March 4, 2005, issue of the *Federal Register* (70 FR 10776) and amended through June 16, 2005, issue of the *Federal Register* (70 FR 35034).

§335.12, Shipping Requirements Applicable to Owners or Operators of Treatment, Storage, or Disposal Facilities

The commission adopts §335.12 by restructuring to separate Texas Class 1 waste from hazardous waste manifest requirements thereby eliminating confusion between the two programs. Manifest requirements for hazardous waste are adopted by reference from EPA rules to ensure consistency. The Uniform Hazardous Waste Manifest requirements are incorporated by reference as published in the March 4, 2005, issue of the *Federal Register* (70 FR 10776) and amended through March 18, 2010, issue of the *Federal Register* (75 FR 12989).

§335.13, Recordkeeping and Reporting Procedures Applicable to Generators Shipping Hazardous Waste or Class 1 Waste and Primary Exporters of Hazardous Waste

The commission adopts §335.13(n) to conform to federal regulations previously promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). Specifically, this amendment will make corrections to typographical errors in the CFR.

The commission adopts §335.13(o) to conform to federal regulations promulgated in the January 8, 2010, issue of the *Federal Register* (75 FR 1236). Specifically, this amendment will implement recent changes to the federal agreements concerning the transboundary movement of hazardous waste among countries belonging to the Organization for Economic Cooperation and Development (OECD), establish notice and consent requirements for spent lead-acid batteries intended for reclamation in a foreign country, specify that all exception reports concerning hazardous waste exports be sent to the International Compliance and Assurance Division in the Office of Enforcement and Compliance Assurance's Office of Federal Activities in Washington, D.C., and require United States receiving facilities to match EPA-provided import consent documentation to incoming hazardous waste import shipments and to submit to EPA a copy of the matched import consent documentation and RCRA hazardous waste manifest for each import shipment. Because of the federal government's special role in matters of foreign policy, EPA does not authorize states to administer federal import/export functions in any section of the RCRA hazardous waste regulations. Although states do not receive authorization to administer the federal government's export functions in 40 CFR Part 262, Subpart E, import functions in 40 CFR Part 262, Subpart F, import/export functions in 40 CFR Part 262, Subpart H, or the import/export related functions in any other section of the RCRA hazardous waste regulations, state programs are required to adopt those federal provisions that are more stringent than existing state requirements to maintain their equivalency with the federal program. This amendment is more stringent than the current state rules. Therefore, this amendment is required by EPA to be adopted into state rules, in order to maintain authorization.

§335.19, Standards and Criteria for Variances from Classification as a Solid Waste

The commission adopts §335.19(b) to conform to federal regulations previously promulgated in the April 4, 2006, issue of the *Federal Register* (71 FR 16862). Specifically, this amendment will reduce the requirements for requests for a variance from classifying as a solid waste those materials that are reclaimed and then reused as feedstock within the original production process in which the materials were generated if the reclamation operation is an essential part of the production process.

§335.24, Requirements for Recyclable Materials and Nonhazardous Recyclable Materials

The commission adopts §335.24(c)(1)(A) to conform to federal regulations promulgated in the January 8, 2010, issue of the *Federal Register* (75 FR 1236). Specifically, this amendment will implement recent changes to the federal agreements concerning the transboundary movement of hazardous waste among countries belonging to the OECD, establish notice and consent requirements for spent lead-acid batteries intended for reclamation in a foreign country, specify that all exception reports concerning hazardous waste exports be sent to the International Com-

pliance and Assurance Division in the Office of Enforcement and Compliance Assurance's Office of Federal Activities in Washington, D.C., and require United States receiving facilities to match EPA-provided import consent documentation to incoming hazardous waste import shipments and to submit to EPA a copy of the matched import consent documentation and RCRA hazardous waste manifest for each import shipment. Because of the federal government's special role in matters of foreign policy, EPA does not authorize states to administer federal import/export functions in any section of the RCRA hazardous waste regulations. Although states do not receive authorization to administer the federal government's export functions in 40 CFR Part 262, Subpart E, import functions in 40 CFR Part 262, Subpart F, import/export functions in 40 CFR Part 262, Subpart H, or the import/export related functions in any other section of the RCRA hazardous waste regulations, state programs are required to adopt those federal provisions that are more stringent than existing state requirements to maintain their equivalency with the federal program. This amendment is more stringent than the current state rules. Therefore, this amendment is required by EPA to be adopted into state rules to maintain authorization.

§335.61, Purpose, Scope and Applicability

The commission adopts §335.61(i) to conform to federal regulations promulgated in the December 1, 2008, issue of the *Federal Register* (73 FR 72912). This amendment adopts exemptions for a specific generator status (i.e., large and small quantity generators and conditionally exempt small quantity generators (CESQGs)) for those eligible academic entities that choose to comply with 40 CFR Part 262, Subpart K (known as the "Academic Laboratories rule"). The Academic Laboratories rule is incorporated by reference in §335.79. The Academic Laboratories rule establishes an alternative set of generator requirements applicable to laboratories owned by eligible academic entities. The alternative requirements are flexible but protective and address the specific nature of hazardous waste generation and accumulation in these laboratories. Further detailed discussion of the Academic Laboratories rule can be found in the Section by Section Discussion in §335.79.

In particular, the amendment to §335.61 will set out exemptions for eligible academic laboratories under different hazardous waste generator statuses. Specifically, this amendment will exempt large and small quantity generators from certain requirements of hazardous waste determination (set out in §335.504) and from the satellite accumulation area rule (set out in §335.69). In addition, this amendment will eliminate exemptions (set out in §335.78) for CESQGs, such as the exemption from regulations under 40 CFR Parts 124, 262 - 266, and 268, and the notification requirements of RCRA, §3010. However, academic laboratories under CESQG status will be able to take advantage of the benefits of the Academic Laboratories rule. Those benefits include the flexibility to decide when and where on-site hazardous waste determinations are made and the incentive to remove old and expired chemicals from the laboratories.

§335.62, Hazardous Waste Determination and Waste Classification

The commission adopts §335.62 to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). The amendment will add a reference to 40 CFR Part 267 which EPA inadvertently omitted after the rule was promulgated in September 8, 2005 (70 FR 53420). The amendment will add 40 CFR Part 267 to a list of Parts (261, 264 - 266, 268, and 273) to which a hazardous waste generator must refer for possible exclusions or restrictions pertaining to managing specific waste.

§335.69, Accumulation Time

The commission adopts §335.69(a)(4)(B) to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). This amendment will correct a limited reference to 40 CFR §268.7(a)(5) which only addresses waste analysis plans. The amendment will apply all applicable requirements under 40 CFR Part 268 (pertaining to Land Disposal Restrictions) to large and small quantity generators.

The commission adopts §335.69(b) to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). The amendment will clarify that the requirements in §335.69(b), pertaining to hazardous waste accumulation time, apply only to large quantity generators.

The commission adopts §335.69(d) to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). The amendment will clarify that the satellite accumulation provisions for large quantity generators are also applicable to small quantity generators. The amendment will also add the citation of 40 CFR §261.31 to clarify that this provision applies to acutely hazardous wastes.

The commission adopts §335.69(e) to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). The amendment will add the citation of 40 CFR §261.31, which was inadvertently omitted after the dioxin listings for acutely hazardous wastes listed under 40 CFR §261.31 were promulgated on April 23, 1985 (50 FR 16044).

The commission adopts §335.69(f)(4)(B) to delete "and" to allow the addition of a new subparagraph.

The commission also renumbers §335.69(f)(4)(C) to §335.69(f)(4)(D) to add a new subparagraph, and also adopts an amendment to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). This amendment will correct a limited reference to 40 CFR §268.7(a)(5) which only addresses waste analysis plans. The amendment will apply all applicable requirements under 40 CFR Part 268 (pertaining to Land Disposal Restrictions) to large and small quantity generators.

The commission adopts §335.69(f)(4)(C) to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). Subparagraph (C) will add 40 CFR Part 267 to the list of other requirements hazardous waste generators must follow. EPA inadvertently did not include 40 CFR Part 267 in the list after the rule was promulgated in September, 2005.

The commission adopts changes to §335.69(m) by adding paragraphs (1) and (2) to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). Specifically, the amendment will incorporate requirements for completion of the manifest regarding rejected loads.

The commission adopts §335.69(n) to separate requirements for rejected loads of hazardous waste from Class 1 waste. The commission adopts §335.69(n) with new language addressing Class 1 waste generators. Specifically, this amendment will add requirements for Class 1 waste to alleviate confusion for requirements for each type of rejected waste.

§335.76, Additional Requirements Applicable to International Shipments

The commission adopts §335.76(a) to conform to federal regulations promulgated in the January 8, 2010, issue of the *Federal Register* (75 FR 1236). This amendment will implement recent changes to the federal agreements concerning the transboundary movement of hazardous waste among countries belonging to the OECD. Specifically, this amendment will clarify that countries belonging to the OECD must comply with the requirements of 40 CFR Part 262, Subpart H (Transfrontier Shipments of Hazardous Waste for Recovery within the OECD).

The commission adopts §335.76(d) to conform to federal requirements promulgated in the March 4, 2005, issue of the *Federal Register* (70 FR 10776) and amended through the March 18, 2010, issue of the *Federal Register* (75 FR 12989). Specifically, the amendment will incorporate requirements for completion of the manifest regarding imports of hazardous waste.

The commission adopts §335.76(f) to conform to federal regulations promulgated in the January 8, 2010, issue of the *Federal Register* (75 FR 1236). This amendment will implement recent changes to the federal agreements concerning the transboundary movement of hazardous waste among countries belonging to the OECD. Specifically, this amendment will clarify that any person who exports hazardous waste to a foreign country or imports hazardous waste from a foreign country into the state must comply with the requirements contained in 40 CFR §262.58 (International Agreements).

The commission adopts §335.76(h) to conform to federal regulations promulgated in the January 8, 2010, issue of the *Federal Register* (75 FR 1236). This amendment will implement recent changes to the federal agreements concerning the transboundary movement of hazardous waste among countries belonging to the OECD. Specifically, this amendment will clarify that transfrontier shipments of hazardous waste for recovery within the countries belonging to the OECD must comply with the requirements of 40 CFR Part 262, Subpart H.

§335.78, Special Requirements for Hazardous Waste Generated by Conditionally Exempt Small Quantity Generators

The commission adopts §335.78(c)(6) to conform to federal regulations promulgated in the December 1, 2008, issue of the *Federal Register* (73 FR 72912). The amendment will remove a period at the end of the paragraph and add the word "or" to allow for an additional paragraph.

The commission adopts §335.78(c)(7) to conform to federal regulations promulgated in the December 1, 2008, issue of the *Federal Register* (73 FR 72912). This amendment will allow an eligible academic entity to exclude the amount of unused commercial chemical product (listed in 40 CFR Part 261, Subpart D or exhibiting one or more characteristics in 40 CFR Part 261, Subpart C) generated solely during a laboratory clean-out from being counted toward its hazardous waste generator status.

The commission adopts §335.78(j) to conform to federal regulations promulgated in the July 30, 2003, issue of the *Federal Register* (68 FR 44659). The amendment will remove the phrase "if it is destined to be burned for energy recovery." This amendment will clarify recycled used oil management standards for CESQGs.

§335.79, Alternative Requirements for Hazardous Waste Determination and Accumulation of Unwanted Material for Laboratories Owned by Eligible Academic Entities

The commission adopts new §335.79 to conform to federal regulations promulgated in the December 1, 2008, issue of the *Federal Register* (73 FR 72912), as amended through the December 20, 2010, issue of the *Federal Register* (75 FR 79304). This new section will incorporate by reference an alternative set of generator requirements applicable to laboratories owned by eligible academic entities promulgated under 40 CFR Part 262, Subpart K. Eligible academic entities are colleges and universities, as well as teaching hospitals and nonprofit research institutes that are either owned by or formally affiliated with a college or university. The Academic Laboratories rule does not apply to non-laboratory generated hazardous wastes from other operations of a university or college nor commercial laboratories.

The Academic Laboratories rule will provide a flexible but protective set of regulations that address the specific nature of hazardous waste generation and accumulation in the laboratories owned or operated by academic entities. Specifically, this rule will allow eligible academic entities the flexibility to make hazardous waste determinations in the laboratory; at an on-site central accumulation area; or at an on-site treatment, storage, or disposal facility. Also, this rule will provide incentives for eligible academic entities to clean-out old and expired chemicals that may pose unnecessary risk. Further, this rule will require the development of a Laboratory Management Plan (LMP) which is expected to result in safer laboratory practices and increased awareness of hazardous waste management.

The adopted rule will be optional for eligible academic entities. That is, eligible academic laboratories could choose to comply with 40 CFR Part 262, Subpart K in lieu of the existing generator regulations. In states authorized to implement the RCRA program, such as Texas, 40 CFR Part 262, Subpart K will only be available as an option once it has been adopted by the state in which the eligible academic entity is located.

The commission incorporates by reference six technical corrections to the Academic Laboratories rule published in the December 20, 2010, issue of the *Federal Register* (75 FR 79304). These changes include correction of errors such as omissions and redundancies as well as removal of an obsolete reference to the now-terminated Performance Track program. These technical corrections will improve the clarity of the state's Academic Laboratories rule. The Academic Laboratories rule and the corrections are recommended by EPA to be adopted into state rules, but are not required to maintain RCRA authorization.

§335.111, Purpose, Scope, and Applicability

The commission adopts §335.111 to make technical corrections.

§335.112, Standards

The commission adopts §335.112(a)(1) to conform to federal regulations promulgated in the January 8, 2010, issue of the *Federal Register* (75 FR 1236). This amendment will implement recent changes to the federal agreements concerning the transboundary movement of hazardous waste among countries belonging to the OECD. Specifically, this amendment will specify that all exception reports concerning hazardous waste exports be sent to the International Compliance and Assurance Division in the Office of Enforcement and Compliance Assurance's Office of Federal Activities in Washington, D.C., and will require United States receiving facilities to match EPA-provided import consent documentation to incoming hazardous waste import shipments and to submit to EPA a copy of the matched import consent documentation and RCRA hazardous waste manifest for each import shipment.

The commission adopts §335.112(a)(3), (4), and (13) to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). Revisions to interim standards for owners and operators of hazardous waste treatment, storage, or disposal facilities in 40 CFR Part 265 are adopted by reference under this section. This amendment will correct citations, clarify regulatory requirements, and incorporate conforming changes that were inadvertently omitted by EPA under the interim standards for owners and operators of hazardous waste treatment, storage, or disposal facilities in 40 CFR Part 265. This amendment is as stringent as the current state rules. EPA recommends that this amendment be adopted into state rules, but it is not required to maintain RCRA authorization.

The commission also adopts §335.112(a)(4), to add language that was inadvertently omitted in a previous rule adoption. Specifically, the new language reinstates the exception to 40 CFR §§265.71, 265.72, 265.75, 265.76, and 265.77 because these requirements are found elsewhere.

The commission also adopts §335.112(a)(14) to conform to federal regulations previously promulgated in the October 12, 2005, issue of the *Federal Register* (70 FR 59402). This amendment was previously adopted into §335.221 which incorporated final National Emission Standards for Hazardous Air Pollutants for hazardous waste combustors. These standards implemented Federal Clean Air Act, §112(d) by requiring hazardous waste combustors to meet hazardous air pollutants emission standards reflecting the performance of the maximum available control technology. In addition, the commission adopts an amendment to §335.112(a)(14) to include this incorporation by reference.

The commission adopts §335.112(b)(7) to update a cross-reference.

§335.151, Purpose, Scope, and Applicability

The commission adopts §335.151 to make technical corrections.

§335.152, Standards

The commission adopts §335.152(a)(1) to conform to federal regulations promulgated in the January 8, 2010, issue of the *Federal Register* (75 FR 1236). This amendment will implement recent changes to the federal agreements concerning the transboundary movement of hazardous waste among countries belonging to the OECD. Specifically, this amendment will specify that all exception reports concerning hazardous waste exports be sent to the International Compliance and Assurance Division in the Office of Enforcement and Compliance Assurance's Office of Federal Activities in Washington, D.C., and will require United States receiving facilities to match EPA-provided import consent documentation to incoming hazardous waste import shipments and to submit to EPA a copy of the matched import consent documentation and RCRA hazardous waste manifest for each import shipment.

The commission also adopts §335.152(a)(4) to add language that was inadvertently omitted in a previous rule adoption. Specifically, the new language reinstates the exception to 40 CFR §§264.71, 264.72, 264.76, and 264.77 because these requirements are found elsewhere.

The commission also adopts §335.152(a)(9) to conform to federal regulations previously promulgated in the July 14, 2006, issue of the *Federal Register* (71 FR 40254). Specifically, this amendment will make corrections to typographical errors in the CFR.

Additionally, the commission adopts §335.152(a)(3), (4), (12), and (14) to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). This amendment will correct citations, clarify regulatory requirements, and incorporate conforming changes that were inadvertently omitted by EPA under the permitting standards for owners and operators of hazardous waste treatment, storage, or disposal facilities in 40 CFR Part 264. This amendment is as stringent as the current state rules. EPA recommends that this amendment be adopted into state rules, but it is not required to maintain RCRA authorization.

The commission adopts §335.152(c)(7) to update a cross-reference.

§335.155, Additional Reports

The commission adopts §335.155 to make technical corrections.

§335.168, Design and Operating Requirements (Surface Impoundments)

The commission adopts §335.168(c) to conform to federal regulations previously promulgated in the July 14, 2006, issue of the *Federal Register* (71 FR 40254). Specifically, this amendment will make corrections to typographical errors in the CFR.

§335.170, Design and Operating Requirements (Waste Piles)

The commission adopts §335.170(c) to conform to federal regulations previously promulgated in the April 4, 2006, issue of the *Federal Register* (71 FR 16862). This amendment adopts by reference requirements that reduce the recordkeeping and reporting burden imposed on the regulated community by ensuring that only the information needed and used to implement the hazardous waste program is collected from facilities. In addition, outdated language that references a construction time period will be deleted. This amendment is less stringent than the current state rules, but the reduction in recordkeeping poses minimal risk to human health or the environment. EPA recommends that this amendment be adopted into state rules, but it is not required to maintain RCRA authorization.

§335.213, Standards Applicable to Storers of Materials That Are To Be Used in a Manner That Constitutes Disposal Who Are Not the Ultimate Users

The commission adopts §335.213 to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). The amendment will add a reference to Chapter 335, Subchapter U, Standards for Owners and Operators of Hazardous Waste Facilities Operating under a Standard Permit, to include applicable requirements in 40 CFR Part 267, which EPA inadvertently omitted after the rule was promulgated in September, 2005.

§335.222, Management Prior to Burning

The commission adopts §335.222(c)(1)(E) to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). Specifically, subparagraph (E) will add a reference to Chapter 335, Subchapter U to include applicable requirements in 40 CFR Part 267, which EPA inadvertently omitted after the rule was promulgated in September, 2005. Subsequent subparagraph (E) has been relettered accordingly.

§335.251, Applicability and Requirements

The commission adopts §335.251(a) to conform to federal regulations promulgated in the January 8, 2010, issue of the *Federal Register* (75 FR 1236). This amendment will implement recent

changes to the federal agreements concerning the transboundary movement of hazardous waste among countries belonging to the OECD. Specifically, this amendment will clarify that entities who transport spent lead-acid batteries in the United States to export them for reclamation in a foreign country or who export spent lead-acid batteries for reclamation in a foreign country are not subject to the requirements of §335.251.

The commission adopts §335.251(b)(1) to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). The amendment will add a reference to Chapter 335, Subchapter U to include applicable requirements in 40 CFR Part 267, which EPA inadvertently omitted after the rule was promulgated in September, 2005.

The commission adopts §335.251(c) to conform to federal regulations promulgated in the January 8, 2010, issue of the *Federal Register* (75 FR 1236). This amendment will implement recent changes to the federal agreements concerning the transboundary movement of hazardous waste among countries belonging to the OECD. Specifically, this amendment will clarify that entities who transport spent lead-acid batteries in the United States to export them for reclamation in a foreign country or who export spent lead-acid batteries for reclamation in a foreign country are subject to the requirements of §335.13 and §335.76(h).

§335.431, Purpose, Scope, and Applicability

The commission adopts §335.431(c)(1) to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). This amendment will correct errors in two tables: Treatment Standards for Hazardous Wastes (40 CFR §268.40) and Universal Treatment Standards (40 CFR §268.48). This amendment is as stringent as current state rules. EPA recommends that this amendment be adopted into state rules, but it is not required to maintain RCRA authorization.

§335.504, Hazardous Waste Determination

The commission adopts §335.504(1) to conform to federal regulations previously promulgated in the July 28, 2006, issue of the *Federal Register* (71 FR 42928). This amendment was inadvertently left out of the last RCRA rulemaking and will exclude CRTs that meet the requirements in 40 CFR §261.4(a)(22) for reuse and recycling from classification as a solid waste. This exclusion is currently found in 40 CFR §261.4. This amendment is less stringent than current state rules and encourages recycling of CRTs. EPA recommends that this amendment be adopted into state rules, but it is not required to maintain RCRA authorization.

The commission also adopts §335.504(1) - (3) to conform to federal regulations promulgated in the March 18, 2010, issue of the *Federal Register* (75 FR 12989). This amendment will correct typographical errors and citations, and incorporate omissions. This amendment is as stringent as the current state rules. EPA recommends that this amendment be adopted into state rules, but it is not required to maintain RCRA authorization.

Final Regulatory Impact Determination

The commission reviewed the adopted rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking is not subject to Texas Government Code, §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in that statute. Although the intent of the rulemaking is to protect the environment and reduce the risk to human health from environmental exposure, the rulemaking is not a major environmental rule because it will not adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. There is no adverse effect in a material way on the economy, a sector of the economy, productivity, competition, or jobs of the state or a sector of the state from those revisions under 42 United States Code (USC), §6926(g), which already imposes the more stringent federal requirements on the regulated community under the Hazardous and Solid Waste Amendments of 1984. Likewise, there will be no adverse effect in a material way on the economy, a sector of the economy, productivity, competition, or jobs of the state or a sector of the state from those revisions outside 42 USC, §6926(g), because either the changes are not substantive, or the regulated community will benefit from the greater flexibility and reduced compliance burden. The regulated community must comply with the more stringent federal requirements beginning on the effective date of the federal regulations. Because the regulated community is already required to comply with the more stringent federal rules, equivalent state rules will not cause any adverse effects. There is no adverse effect in a material way on the environment, or the public health and safety of the state or a sector of the state because the rulemaking is designed to protect the environment, the public health, and the public safety of the state and all sectors of the state. Because the adopted rulemaking does not have an adverse material impact on the economy, the rulemaking does not meet the definition of a major environmental rule. Furthermore, the rulemaking does not meet any of the four applicability requirements listed in Texas Government Code, §2001.0225(a). First, the adopted rulemaking does not exceed a standard set by federal law because the commission adopts this rulemaking to implement revisions to the federal hazardous waste program. The commission must meet the minimum standards and mandatory requirements of the federal program to maintain authorization of the state hazardous waste program. The other adopted changes do not alter substantive requirements although various changes may increase flexibility for the regulated community. Second, although the rulemaking adopts some requirements that are more stringent than existing state rules, federal law requires the commission to promulgate rules that are as stringent as federal law for the commission to maintain authorization of the state hazardous waste program. Third, the rulemaking does not exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government, where the delegation agreement or contract is to implement a state and federal program. On the contrary, the commission must undertake the waste program. And fourth, the rulemaking does not seek to adopt a rule solely under the general powers of the agency instead of under a specific state law. The commission adopts this rulemaking under Texas Water Code, §5.103 and §5.105 and under Texas Health and Safety Code, §361.017 and §361.024.

The commission invited public comment regarding the draft regulatory impact analysis determination during the public comment period, but received no comments relating to this subject.

Takings Impact Assessment

The commission evaluated the rulemaking and performed an assessment of whether Texas Government Code, Chapter 2007 applies. The commission's assessment indicates that Texas Government Code, Chapter 2007 does not apply to the adopted rulemaking because this action is reasonably taken to fulfill an obligation mandated by federal law; therefore, this action is exempt under Texas Government Code, §2007.003(b)(4). The specific purpose of the rulemaking is to maintain state RCRA

authorization by adopting state hazardous waste rules that are equivalent to the federal regulations. The rulemaking substantially advances this purpose by adopting rules that incorporate and refer to the federal regulations. Promulgation and enforcement of the rules is not a statutory or constitutional taking of private real property. Specifically, the adopted rulemaking does not affect a landowner's rights in private real property because this rulemaking does not constitutionally burden the owner's right to property, does not restrict or limit the owner's right to property, and does not reduce the value of property by 25% or more beyond that which would otherwise exist in the absence of the regulations. The rulemaking seeks to meet the minimum standards of federal RCRA regulations that are already in place. 42 USC, §6926(g) imposes on the regulated community any federal requirements that are more stringent than current state rules. The regulated community must already have complied with the more stringent federal requirements as of the effective date of the federal regulations. Because the regulated community is already required to comply with the more stringent federal regulations, promulgating equivalent state rules does not burden, restrict, or limit the owner's right to property and does not reduce the value of property by 25% or more. Likewise, the regulated community is not unduly burdened by those revisions providing greater flexibility, reduced recordkeeping, reporting, inspection, and sampling requirements.

Consistency with the Coastal Management Program

The commission reviewed the adopted rulemaking and found that the adoption is subject to the Texas Coastal Management Program (CMP) in accordance with the Coastal Coordination Act, Texas Natural Resources Code, §§33.201 *et seq.,* and therefore must be consistent with all applicable CMP goals and policies. The commission conducted a consistency determination for the adopted rules in accordance with Coastal Coordination Act Implementation Rules, 31 TAC §505.22 and found the adopted rulemaking is consistent with the applicable CMP goals and policies. The CMP goal applicable to the rulemaking is to protect, preserve, restore and enhance the diversity, quality, quantity, functions and values of coastal natural resource areas (CNRAs). Applicable policies are construction and operation of solid waste treatment, storage, and disposal facilities, such that new solid waste facilities and areal expansions of existing solid waste facilities shall be sited, designed, constructed, and operated to prevent releases of pollutants that may adversely affect CNRAs and, at a minimum, comply with standards established under the Solid Waste Disposal Act, 42 USC, §§6901 *et seq.* Promulgation and enforcement of these rules are consistent with the applicable CMP goals and policies because the rulemaking will update and enhance the commission's rules concerning hazardous waste facilities. In addition, the rules will not violate any applicable provisions of the CMP's stated goals and policies.

The commission invited public comment regarding the consistency of this rulemaking with the CMP during the public comment period, but received no comments relating to this subject.

Public Comment

The comment period closed on November 5, 2012. No comments were received.

SUBCHAPTER A. INDUSTRIAL SOLID WASTE AND MUNICIPAL HAZARDOUS WASTE IN GENERAL

30 TAC §§335.1, 335.2, 335.10 - 335.13, 335.19, 335.24

Statutory Authority

The amendments are adopted under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste); THSC, §361.024 (relating to Rules and Standards); and THSC, §361.036 (relating to Records and Manifests Required: Class I Industrial Solid Waste or Hazardous Waste) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The adopted amendments implement THSC, Chapter 361.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300392
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: February 21, 2013
Proposal publication date: October 5, 2012
For further information, please call: (512) 239-0779

♦ ♦ ♦

SUBCHAPTER C. STANDARDS APPLICABLE TO GENERATORS OF HAZARDOUS WASTE

30 TAC §§335.61, 335.62, 335.69, 335.76, 335.78, 335.79

Statutory Authority

The amendments and new section are adopted under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste); THSC, §361.024, (relating to Rules and Standards); and THSC, §361.036 (relating to Records and Manifests Required: Class I Industrial Solid Waste or Hazardous Waste) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The adopted amendments and new section implement THSC, Chapter 361.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300399
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: February 21, 2013
Proposal publication date: October 5, 2012
For further information, please call: (512) 239-0779

♦ ♦ ♦

SUBCHAPTER E. INTERIM STANDARDS FOR OWNERS AND OPERATORS OF HAZARDOUS WASTE TREATMENT, STORAGE, OR DISPOSAL FACILITIES

30 TAC §335.111, §335.112

Statutory Authority

The amendments are adopted under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste); THSC, §361.024 (relating to Rules and Standards); and THSC, §361.036 (relating to Records and Manifests Required: Class I Industrial Solid Waste or Hazardous Waste) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The adopted amendments implement THSC, Chapter 361.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300400
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: February 21, 2013
Proposal publication date: October 5, 2012
For further information, please call: (512) 239-0779

♦ ♦ ♦

SUBCHAPTER F. PERMITTING STANDARDS FOR OWNERS AND OPERATORS OF HAZARDOUS WASTE TREATMENT, STORAGE, OR DISPOSAL FACILITIES

30 TAC §§335.151, 335.152, 335.155, 335.168, 335.170

Statutory Authority

The amendments are adopted under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste); THSC, §361.024 (relating to Rules and Standards); and THSC, §361.036 (relating to Records and Manifests Required: Class I Industrial Solid Waste or Hazardous Waste) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The adopted amendments implement THSC, Chapter 361.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300401
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: February 21, 2013
Proposal publication date: October 5, 2012
For further information, please call: (512) 239-0779

♦ ♦ ♦

SUBCHAPTER H. STANDARDS FOR THE MANAGEMENT OF SPECIFIC WASTES AND SPECIFIC TYPES OF FACILITIES
DIVISION 1. RECYCLABLE MATERIALS USED IN A MANNER CONSTITUTING DISPOSAL

30 TAC §335.213

Statutory Authority

The amendment is adopted under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste); THSC, §361.024 (relating to Rules and Standards); and THSC, §361.036 (relating to Records and Manifests Required: Class I Industrial Solid Waste or Hazardous Waste) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The adopted amendment implements THSC, Chapter 361.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300402

Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: February 21, 2013
Proposal publication date: October 5, 2012
For further information, please call: (512) 239-0779

♦ ♦ ♦

DIVISION 2. HAZARDOUS WASTE BURNED FOR ENERGY RECOVERY

30 TAC §335.222

Statutory Authority

The amendment is adopted under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste); THSC, §361.024 (relating to Rules and Standards); and THSC, §361.036 (relating to Records and Manifests Required: Class I Industrial Solid Waste or Hazardous Waste) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The adopted amendment implements THSC, Chapter 361.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300403
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: February 21, 2013
Proposal publication date: October 5, 2012
For further information, please call: (512) 239-0779

♦ ♦ ♦

DIVISION 4. SPENT LEAD-ACID BATTERIES BEING RECLAIMED

30 TAC §335.251

Statutory Authority

The amendment is adopted under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste); THSC, §361.024 (relating to Rules and Standards); and THSC, §361.036 (relating to Records and Manifests Required: Class I Industrial Solid Waste or Hazardous Waste) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The adopted amendment implements THSC, Chapter 361.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300404
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: February 21, 2013
Proposal publication date: October 5, 2012
For further information, please call: (512) 239-0779

♦ ♦ ♦

SUBCHAPTER O. LAND DISPOSAL RESTRICTIONS

30 TAC §335.431

Statutory Authority

The amendment is adopted under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC) §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste); THSC, §361.024 (relating to Rules and Standards); and THSC, §361.036 (relating to Records and Manifests Required: Class I Industrial Solid Waste or Hazardous Waste) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The adopted amendment implements THSC, Chapter 361.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300405
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: February 21, 2013
Proposal publication date: October 5, 2012
For further information, please call: (512) 239-0779

♦ ♦ ♦

SUBCHAPTER R. WASTE CLASSIFICATION

30 TAC §335.504

Statutory Authority

The amendment is adopted under Texas Water Code (TWC), §5.103 (relating to Rules) and TWC, §5.105 (relating to General Policy) which provide the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC or other laws of this state; and under Texas Health and Safety Code (THSC), §361.017 (relating to Commission's Jurisdiction: Industrial Solid Waste and Hazardous Municipal Waste); THSC, §361.024 (relating to Rules and Standards); and THSC, §361.036 (relating to Records and Manifests Required: Class I Industrial Solid Waste or Hazardous Waste) which authorize the commission to regulate industrial solid waste and hazardous waste and to adopt rules consistent with the general intent and purposes of the THSC.

The adopted amendment implements THSC, Chapter 361.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300406
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: February 21, 2013
Proposal publication date: October 5, 2012
For further information, please call: (512) 239-0779

♦ ♦ ♦

TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 1. GENERAL LAND OFFICE

CHAPTER 15. COASTAL AREA PLANNING
SUBCHAPTER A. MANAGEMENT OF THE BEACH/DUNE SYSTEM

31 TAC §15.29

The General Land Office (GLO) adopts amendments to 31 TAC §15.29, relating to Certification Status of City of the Village of Jamaica Beach Dune Protection and Beach Access Plan (Plan), without changes to the proposed text as published in the November 2, 2012, issue to the *Texas Register* (37 TexReg 8755). The text of the rule as adopted will not be republished. The amendment to §15.29 deletes the certification of variances in the plan in subsection (b), which is no longer required because they are consistent with current state law. The amendment then adopts a new subsection (b) which certifies as consistent with state law the City of the Village of Jamaica Beach Dune Protection and Beach Access Plan, as amended by the Erosion Response Plan (ERP), which was adopted by the City of the Village of Jamaica Beach (City) by ordinance on July 16, 2012.

Copies of the adopted Plan or any amendments to the Plan are available from the City of the Village of Jamaica Beach at 16628 San Luis Pass Road, City of Jamaica Beach, Texas 77554, and from the GLO's Archives Division, Texas General Land Office, P.O. Box 12873, Austin, Texas 78711-2873, phone number (512) 463-5277.

BACKGROUND

The City is a coastal city located on Galveston Island, a barrier island accessible from the east via Interstate Highway 45 and FM 3005, and from the west via State Highway 332, Bluewater Highway, and the bridge at San Luis Pass. The City consists of areas bordering Galveston Bay to the northwest and the Gulf of Mexico to the southeast, and bordered on the northeast and the southwest by the City of Galveston. The City includes approximately 2/3 miles of beach bordering on the Gulf of Mexico. The areas governed by the Plan include those beaches and adjacent areas bordering the Gulf of Mexico located in within the City.

Pursuant to §33.607 of the Coastal Public Lands Management Act of 1973 (Texas Natural Resources Code, Chapter 33) and the Beach Dune Rules (31 TAC §15.17) the City has prepared an ERP and submitted it to the GLO for certification as an amendment to its Plan. Pursuant to the Open Beaches Act (Texas Natural Resources Code, Chapter 61), the Dune Protection Act (Texas Natural Resources Code, Chapter 63), and the Beach/Dune Rules (31 TAC §15.3), a local government with jurisdiction over Gulf beaches must submit its dune protection and beach access plan and any amendments to such a plan to the GLO for certification. The City amended its Plan to include the ERP by ordinance on July 16, 2012. The GLO is required to review such plans and certify by rule those plans that are consistent with the Open Beaches Act, and the Dune Protection Act, and 31 TAC Chapter 15. The certification by rule reflects the state's approval of the plan, but the text of the plan is not adopted by the GLO under 31 TAC §15.3(o)(4).

THE CITY OF THE VILLAGE OF JAMAICA BEACH AMENDMENTS

Based on the information provided by the City, the GLO has determined that the ERP is consistent with the Open Beaches Act, the Dune Protection Act, and the 31 TAC Chapter 15 and that the requirements of the ERP are incorporated into the City's Plan and procedures for reviewing and approving permit applications. Therefore, the GLO finds that the approved amendments to the Plan are consistent with state law and hereby approves and certifies the City's Erosion Response Plan (ERP) as an amendment to its Plan.

REASONED JUSTIFICATION

The justification for the adopted amendment is that implementation of an ERP will preserve and enhance dunes, which delays erosion, reduces the intensity of storm surges and increases protection for infrastructure located in coastal areas. Construction standards established in the ERP will increase protection against erosion and storms for structures located within or landward of the dune conservation area. Construction requirements will reduce loss of life and reduce public expenditures associated with damage to and loss of public infrastructure due to erosion, storm damage, and disaster response costs. The identification of restoration areas in the ERP will focus mitigation and restoration efforts in areas that may be vulnerable to storm inundation and are potential avenues for floodwaters that may cause damage to public infrastructure and private properties. The setback line in the ERP allows for the formation of dunes, which maintains a natural buffer against normal storm tides and allows dune processes to function with minimal disturbance to the dune system and property owners. Preservation of and improvements to foredune ridges protect existing structures and properties against damage from storm surge and reduce the possibility of structures becoming located on state-owned submerged lands, which

results in a loss to landowners and increases expenditure of public funds for removal of the unauthorized structures from public beaches. Improvements to beach access points preserve public access and protect against degradation of coastal areas by erosion and storm surge.

SUMMARY AND RESPONSE TO COMMENTS

No public comments were received during the thirty (30) day comment period.

CONSISTENCY WITH COASTAL MANAGEMENT PROGRAM

The amendment to §15.29 (Certification Status of City of the Village of Jamaica Beach Dune Protection and Beach Access Plan) is subject to the Coastal Management Program (CMP) goals and policies as provided in Texas Natural Resources Code §33.2051(c) and §33.2053(a)(10). The applicable CMP goals and policies are found under 31 TAC §501.11, relating to Goals, and §501.26, relating to Policies and Construction in the Beach/Dune System. The GLO reviewed the amendment for consistency and determined that the amendment is consistent with the Beach/Dune regulations and the applicable CMP goals and policies. No comments were received from the public or the Commissioner regarding the consistency determination. Consequently, the GLO has determined that the adopted rule amendment is consistent with the applicable CMP goals and policies.

STATUTORY AUTHORITY

The amendment is adopted under Texas Natural Resources Code §33.607 and §61.011 relating to GLO's authority to adopt rules to preserve and enhance the public's right to access the public beach and reduce public expenditures from erosion and storm damage to public and private property, including public beaches. Texas Natural Resources Code §§33.601 - 33.613 and §61.015 are affected by the proposed amendments.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 31, 2013.

TRD-201300367
Larry Laine
Chief Clerk, Deputy Land Commissioner
General Land Office
Effective date: February 20, 2013
Proposal publication date: November 2, 2012
For further information, please call: (512) 475-1859

♦ ♦ ♦

TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 19. DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

CHAPTER 700. CHILD PROTECTIVE SERVICES

SUBCHAPTER O. FOSTER AND ADOPTIVE HOME DEVELOPMENT

40 TAC §700.1502

The Health and Human Services Commission adopts, on behalf of the Department of Family and Protective Services (DFPS), an amendment to §700.1502 with changes to the proposed text published in the November 16, 2012, issue of the *Texas Register* (37 TexReg 9071). The justification for the amendment is to provide for a general clean-up of language to ensure consistency with current agency policy and with language commonly used by Foster and Adoptive (FAD) staff. The adoption also provides for flexibility relating to age of parents to adopt, a length of marriage requirement, and divorce finalization requirements that had previously rendered certain prospective adoptive parents ineligible for approval to adopt.

The amendment to paragraph (2)(A) deletes the requirement that foster and adoptive applicants must have a life expectancy to be able to raise a child to adulthood. The DFPS age requirements go further than what is currently mandated by minimum standards. A good number of grandparents and older relatives are applying to adopt relatives, and DFPS does not want to discourage older family members from being considered as possible placements, nor does DFPS want older family members to believe that their age automatically disqualifies them from consideration.

The amendment to paragraph (2)(B): (1) clarifies that a married couple not separated must submit a joint application to adopt; and (2) allows the Child Protective Services (CPS) Assistant Commissioner, or a designee, to issue a waiver to the rule that prospective adoptive applicants who are separated but not divorced must finalize their divorce before DFPS FAD staff will issue an approval to adopt. The waiver may be granted if it is established that it is in the "best interests" of a child to do so. The amendment also provides examples of factors that may be used in the "best interests" analysis. Factors include, but are not limited to, family relationship between the prospective applicant and the child, prior relationship between the prospective applicant and the child, and the applicant's ability to meet the child's needs as set forth in the home screening.

Paragraph (2)(C) amends the previous requirement that a couple be married at least two years before submitting an application to adopt. The amendment clarifies that DFPS has a preference that couples be married at least two years before adopting; however, DFPS will accept adoption applications from couples who have not been married for two years. In these situations, the individual conducting the home study must assess the stability of the couple's relationship and their reasons for wanting to adopt. This information will be used by the individual conducting the home study to determine whether the home study should be initially approved. Child Placement Management Staff will make the final determination of approval of the home study.

The amendment will function by allowing exceptions to be made for separated and not divorced adoptive applicants when in the best interest of a child. Additionally, couples not married for more than two years will be able to submit an application for adoption if DFPS staff assesses the couple's relationship to be stable. Finally, grandparents and older relatives will be more likely to apply to adopt relatives and can be approved when in the best interest of children. This will open up the adoption process and likely result in increasing the number of approved adoptive homes.

During the comment period, DFPS received comments from DePelchin Children's Center. A summary of the comments and responses follows:

Comment concerning paragraph (2)(A): The commenter supports this amendment, which would allow aging grandparents and older relatives to be considered as a possible adoption or foster placement. This is imperative to meet the demand and need for safe, healthy placements for children in the DFPS system.

Response: DFPS appreciates the comment.

Comment concerning paragraph (2)(B): The commenter supports the added paragraph (2)(B)(i) that clarifies consistencies between promulgated RCCL standards for Foster and Adoptive Home Inquiry and Screening, the added paragraph (2)(B)(ii)(I) that clarifies a married couple that is not separated must both join in the application, and the added paragraph (2)(B)(ii)(III) clarifying that prospective adoptive applicants who are separated but not yet divorced can apply for a waiver to successfully adopt. However, this waiver option and a process developed to apply to private child placing agencies must be extended to prospective foster/adoptive applicants who are working with private child placing agencies as well. The issue of separated but not yet divorced couples exists within the population of adoptive and foster parents, and the waivers should extend to both for consistency and to remove superfluous barriers to placements for children. Without amending this proposed amendment to include foster parents, we cannot lend our support.

Response: DFPS appreciates the supportive comments. DFPS does not agree with the comment requesting that the waiver process also apply to foster parents and is adopting this provision with no changes. Current Child Care Licensing (CCL) rules preclude an internal waiver process for foster parent verification. Section 749.2401 of this title (relating to If one spouse will not be involved in the care of foster children, may I verify the spouse who will provide care individually as a foster parent?) is a CCL rule relating specifically to Child Placing Agencies (CPA), which states that a CPA must verify both foster parents. The individual Regions of DFPS are each a licensed CPA that must comply with the CCL rules. If a CPA wants to verify one foster parent of a married couple, the CPA may request a waiver to §749.2401 from CCL.

Comment concerning paragraph (2)(C): The commenter supports amendments to clarify that "generally couples must be married for at least two years" before submitting an application to adopt, but that FAD staff will now accept applications before that time and will evaluate on an individual basis.

Response: DFPS appreciates the comment.

Also, several DFPS council members had comments at the Council meeting. A summary of the council members' comments and DFPS's responses follows:

Comment: There were some general comments by council members suggesting that this rule packet also needed to discuss single individuals and whether they are allowed to adopt a child. However, one council member clarified with a question that the fact that there were no rules relating to single individuals adopting meant there were no specific prohibitions in this rule packet to individuals adopting. The General Counsel clarified that this is true, however, he did note that Child Care Licensing did require all individuals to meet Licensing standards regarding adoption, including background checks and completion and approval of a home study.

Response: Section 700.1502(2)(D) was not being changed, so it was listed in the rule packet as "no change". However, the paragraph does address the issue of single individuals adopting, so the original language of paragraph (D) has been added to the rule packet for clarification purposes. Any other change to this paragraph would be considered a substantive change and could not be made during this comment period without having to re-propose the rules. Child Protective Services program staff did agree to take a look at this issue in the future to determine if new rules regarding this matter were needed.

Comment: One of the council members suggested that the language relating to §700.1502(2)(C) and Length of Marriage might seem confusing to workers and should be more specific. There was also discussion regarding whether or not application materials regarding this matter would be changed.

Response: DFPS agrees with the commenter and has clarified the language for §700.1502(2)(C). Program staff are also reviewing the application materials that need to be changed.

The amendment is adopted under Human Resources Code (HRC) §40.0505 and Government Code §531.0055, which provide that the Health and Human Services Executive Commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including the Department of Family and Protective Services; and HRC §40.021, which provides that the Family and Protective Services Council shall study and make recommendations to the Executive Commissioner and the Commissioner regarding rules governing the delivery of services to persons who are served or regulated by the department.

The amendment implements HRC §40.002.

§700.1502. Foster and Adoptive Home Inquiry and Screening.

The Texas Department of Family and Protective Services' (DFPS') policies for responding to inquiries and screening and approval of foster and adoptive homes are as follows:

(1) Responding to inquiries. DFPS receives inquiries as a result of recruitment efforts by staff, volunteers, foster and adoptive parents, foster and adoptive parent associations, and other organizations that work with DFPS. When inquiries are received, staff should provide a written response within 10 working days to provide families information about the process of becoming a foster or adoptive parent with DFPS.

(2) Screening. When screening prospective foster and adoptive parents, DFPS considers both the Minimum Standards promulgated by Residential Child Care Licensing (RCCL) and the following factors:

(A) Age. Applicants to foster or adopt must be at least 21 years of age. Age is evaluated in relation to the applicant's maturity.

(B) Marriage.

(i) Regarding foster parents, DFPS follows the Minimum Standards promulgated by RCCL that govern married applicants. In order for one spouse to be a foster parent, both spouses must be verified to provide foster care.

(ii) Regarding adoptive parents:

(I) If an applicant is married but not separated and wishes to submit an application, the applicant's spouse must join in the application and the license or declaration of marriage must be recorded.

(II) Except as provided in subclause (III) of this clause, if an applicant is separated but not divorced, he or she may

submit an application, but is required to finalize the divorce before the home can be approved.

(III) If an applicant seeking to adopt does not have a finalized divorce, the Assistant Commissioner of Child Protective Services, or designee, may grant a waiver if it is in the best interest of the child to do so. Relevant factors in assessing whether to grant a waiver include, but are not limited to, any family relationship between the applicant and the child, any other significant prior relationship between the applicant and the child, and the applicant's ability to meet the child's particular needs as evidenced in an adoptive home screening.

(C) Length of marriage. DFPS has a preference that couples should be married at least two years before adopting. However, DFPS does accept adoption applications from couples who have not been married for at least two years. In this situation, an individual conducting the home study must assess the stability of the couple's relationship and their reason for wanting to adopt a child, this will include looking at any current or prior family or other significant relationships between the applicant and the child. This information will be used by the individual conducting the home study in determining whether the home study will be initially approved. Once the home study is initially approved, it must also be approved by a Child Placement Management Staff.

(D) Single Parents. Single parents are evaluated in terms of their ability to nurture and provide for a child without assistance of a spouse. Placement with a single parent is considered the best plan for some children.

(E) Disabilities. Disabilities are evaluated in relation to the applicants' adjustment to the disability and the limits, if any, that the disability imposes on the applicants' ability to care for a child.

(F) Residence. Adoptive home screenings are started only if the applicant(s) will live in the community long enough for DFPS to complete a screening and make a placement. Exceptions are made in unusual situations involving a child with special needs if another licensed child placing agency in the new community agrees to complete the adoption services.

(G) Adoption by foster families. Foster families are evaluated using the same criteria applied to any other adoptive applicants. The home screening must be updated to meet the minimum standards for adoptive homes. The evaluation focuses on the family's demonstrated skill and ability to parent the children DFPS has placed in the family's care and determines the attachment the family and the child have to each other.

(H) Finances. Although there are no specific income requirements, the applicants must have enough income, and be able to manage it well enough, to meet the child's basic material needs. Income is also evaluated in terms of past and present management.

(I) Health. The applicants' physical, mental, and emotional health must be sufficient to assume parenting responsibilities. Physical, mental, and emotional conditions are considered to protect the child against another loss of parenting through death, incapacity, or repetition of abuse or neglect.

(J) Religion. There are no specific religion requirements. Applicants are evaluated based on:

(i) Their willingness to respect and encourage a child's religious affiliation.

(ii) Their willingness to provide a child opportunity for religious, spiritual, and ethical development.

(iii) The health protection they plan to give a child if their religious beliefs prohibit certain medical treatment.

(K) Discipline. Physical discipline may not be used on a child in any DFPS foster or adoptive home prior to consummation. DFPS evaluates applicants based on their willingness and ability to:

(i) recognize and respect differences in children, especially children who have been abused or neglected;

(ii) employ methods of discipline that suit the particular needs and circumstances of each child; and

(iii) employ methods of discipline that conform to the policies specified in the Minimum Standards promulgated by Residential Child Care Licensing.

(L) Criminal history. Criminal history background checks must be completed on all prospective foster and adoptive parents and the members of their households who are 14 years old or older and not under the legal conservatorship of DFPS. Criminal history background checks are conducted in accordance with the criminal history rules promulgated by the Child Care Licensing Division of DFPS.

(M) Adoptive home screenings - fertility. Fertility assessments may be needed if DFPS believes the couple needs to know more about their fertility before they adopt a child. The couple's fertility is important only in relation to resolution of their feelings about their infertility and their ability to accept and parent a child not born to them.

(N) Citizenship and immigration. Only U.S. citizens, permanent residents, or other qualified aliens (as defined in 8 U.S.C. §1641(b)) can be approved as foster or adoptive parents. If an applicant who seeks to adopt a child does not have the required immigration status, the Assistant Commissioner of Child Protective Services or a designee, may grant a waiver if it is in the best interest of the child to do so. Relevant factors in assessing whether to grant a waiver include any family relationship or other significant prior relationship between the child and the applicant, and the applicant's ability to meet the child's particular needs.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 30, 2013.

TRD-201300362
Gerry Williams
General Counsel
Department of Family and Protective Services
Effective date: March 1, 2013
Proposal publication date: November 16, 2012
For further information, please call: (512) 438-3437

♦ ♦ ♦

CHAPTER 745. LICENSING

The Health and Human Services Commission adopts, on behalf of the Department of Family and Protective Services (DFPS), amendments to §745.903 and §745.915; the repeal of §745.911 and §745.913; and new §745.911 and §745.913 without changes to the proposed text published in the November 16, 2012, issue of the *Texas Register* (37 TexReg 9073). The justification for the amendments, repeals, and new sections is to implement legis-

lation passed during the 82nd Legislative Session. Senate Bill (S.B.) 1178, 82nd Legislature, made changes to Chapter 42 of the Human Resources Code (HRC) in regards to who is ineligible to be a controlling person at an operation regulated by Child Care Licensing (CCL). Earlier this year, CCL amended administrative rules to implement the legislation (the rules became effective March 1, 2012). These changes will further support the implementation of S.B. 1178 by outlining in what circumstances a person is prohibited from being a controlling person, when CCL will make this determination, and updating the rules. Also, DFPS is changing the name of Subchapter G to Controlling Persons.

The amendment to §745.903 clarifies the alternatives for submitting controlling-person information to CCL.

New §745.911, which replaces repealed §745.911, outlines the circumstances when a person may not serve as a controlling person at a child-care operation.

New §745.913, which replaces repealed §745.913, simplifies the times when CCL checks whether a person is ineligible to serve as a controlling person at a child-care operation.

The amendment to §745.915 updates the language of this rule to be consistent with the new statute, which precludes certain persons from being controlling persons, but does not preclude those persons from being employed in child-care.

The sections will function by providing the public a clearer understanding of who can serve as controlling persons, and children will be safer in regulated child-care settings because CCL will not allow ineligible persons to serve as controlling persons.

During the public comment period, DFPS received a comment from DePelchin Children's Center concerning §745.911. The commenter expressed concern that the use of the term "sustained" in paragraph (1) of the rule may lead to confusion and misinterpretation as some people may interpret the word to mean "allow." The commenter suggested changing the term "sustained" to "denied" to ensure consistent application and interpretation of the rule. DFPS is adopting this section without change. Section 745.911 must be read in context of other rules related to controlling persons, including §745.907(b) of this title (relating to What are the consequences of Licensing designating me as a controlling person?), which describes that a designated controlling person becomes sustained when the revocation or voluntary closure described in §745.905 of this title (relating to When will Licensing designate someone at my child-care operation as a controlling person?) is final and after due process rights have been waived or upheld.

SUBCHAPTER G. CONTROLLING PERSONS

40 TAC §§745.903, 745.911, 745.913, 745.915

The amendments and new sections are adopted under Human Resources Code (HRC) §40.0505 and Government Code §531.0055, which provide that the Health and Human Services Executive Commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including the Department of Family and Protective Services; and HRC §40.021, which provides that the Family and Protective Services Council shall study and make recommendations to the Executive Commissioner and the Commissioner regarding rules governing the delivery of services to persons who are served or regulated by the department.

The amendments and new sections implement HRC §§42.042, 42.062, and 42.072(c-1).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 30, 2013.

TRD-201300357
Gerry Williams
General Counsel
Department of Family and Protective Services
Effective date: March 1, 2013
Proposal publication date: November 16, 2012
For further information, please call: (512) 438-3437

♦ ♦ ♦

SUBCHAPTER G. CONTROLLING PERSON AND CERTAIN EMPLOYMENT PROHIBITED

40 TAC §745.911, §745.913

The repeals are adopted under Human Resources Code (HRC) §40.0505 and Government Code §531.0055, which provide that the Health and Human Services Executive Commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including the Department of Family and Protective Services; and HRC §40.021, which provides that the Family and Protective Services Council shall study and make recommendations to the Executive Commissioner and the Commissioner regarding rules governing the delivery of services to persons who are served or regulated by the department.

The repeals implement HRC §§42,042, 42.062, and §42.072(c-1).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 30, 2013.

TRD-201300358
Gerry Williams
General Counsel
Department of Family and Protective Services
Effective date: March 1, 2013
Proposal publication date: November 16, 2012
For further information, please call: (512) 438-3437

♦ ♦ ♦

SUBCHAPTER K. INSPECTIONS AND INVESTIGATIONS
DIVISION 3. CONFIDENTIALITY

40 TAC §745.8491, §745.8493

The Health and Human Services Commission adopts, on behalf of the Department of Family and Protective Services (DFPS), amendments to §745.8491 and §745.8493, in its Licensing chapter. The amendment to §745.8493 is adopted with changes to the proposed text published in the November 16, 2012, issue of the *Texas Register* (37 TexReg 9074). The amendment to

§745.8491 is adopted without changes to the proposed text and will not be republished. The justification for the amendments is to clarify confidentiality requirements relating to Child Care Licensing (CCL) abuse or neglect investigation records.

The amendment to §745.8491 outlines who can obtain confidential information from an abuse or neglect investigation that is not in the operation's monitoring file. The changes: (1) add language that the parent of the child who is an alleged perpetrator in the investigation has the right to confidential information; (2) amend language that currently states that records will be released to an operation that is "cited for abuse or neglect" to "cited for a deficiency"; and also allow a single-source continuum contractor (SSCC) for foster care redesign to receive this information from their subcontractors with a signed release when the operation is cited for a deficiency; (3) add language to allow prospective adoptive parents to review CCL abuse or neglect records relevant to the child they plan to adopt who is either the subject of the investigation or is an alleged perpetrator in the investigation; and (4) allow the parent of a child who is not the subject of or the alleged perpetrator in the investigation but was a collateral witness in the investigation to obtain the portion of the investigation record relating to their child.

The amendment to §745.8493 outlines which portions of abuse or neglect investigation records are confidential and not releasable to anyone. The changes: (1) clarify that in addition to the reporter's name being confidential, any information that identifies the reporter is also confidential; (2) prohibit the release of identities of children except to the parent or prospective adoptive parent, or an operation (or the SSCC) that was cited for a deficiency as a result of the investigation. The rule also states that notwithstanding the fact that some information is not releasable, there are certain entities in specific situations that can also obtain this confidential information (e.g., DFPS staff, law enforcement, state legislators, and individuals with court orders). Finally, DFPS may withhold information in its records if agency staff, in consultation with the Office of General Counsel, deems it necessary to ensure the safety of an individual.

The amendments will function by ensuring that an operation and an SSCC will have the opportunity to review the record that resulted in a minimum standard citation the operation received during the course of an investigation; a parent or prospective adoptive parent will have access to important information regarding a child's abuse or neglect history with Licensing; a child's identity will be protected and kept confidential; and an individual's safety may be considered in a request for confidential records.

No comments were received concerning the amendment during the comment period. However, one DFPS council member had a comment concerning §745.8493(c) at the Council meeting. The council member was concerned that the rule was written as though DFPS had absolute authority to decide not to release certain items. DFPS has clarified the rule to state that CCL staff must consult with the Office of General Counsel before withholding information for safety purposes.

The amendments are adopted under Human Resources Code (HRC) §40.0505 and Government Code §531.0055, which provide that the Health and Human Services Executive Commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including the Department of Family and Protective Services; and HRC §40.021, which provides that the Family and Protective Services Council shall study and make recommendations to the Executive Commissioner and the Commissioner regarding rules governing the delivery of services to persons who are served or regulated by the department.

The amendments implement HRC §40.005 and §42.042.

§745.8493. Are there any portions of a child abuse or neglect investigation file that Licensing may not release to anyone?

(a) We may not release the following portions of an abuse or neglect investigation file to anyone:

(1) The audio taped or videotaped interview of a child, as well as any photographs taken of a child. An authorized person may review them but may not have copies;

(2) Any information that would interfere with an ongoing law enforcement investigation or prosecution;

(3) The name of the person who made the report or any information identifying this person;

(4) The location of a family violence shelter;

(5) Information pertaining to an individual who was provided family violence services; and

(6) The identity of any child or information identifying the child, unless the requestor is:

(A) The child's parent or prospective adoptive parent;

(B) The operation that was cited for a deficiency as a result of the investigation; or

(C) The single-source continuum contractor (SSCC) for foster care redesign when:

(i) The SSCC subcontracts with the operation;

(ii) The operation has signed a release of information; and

(iii) The operation was cited for a deficiency as a result of the investigation.

(b) Notwithstanding any other provision in this section, DFPS may provide any of the above confidential information to the following parties in the relevant situations:

(1) DFPS staff, including volunteers, as necessary to perform their assigned duties;

(2) Law enforcement for the purpose of investigating allegations of child abuse or neglect or false or malicious reporting of alleged child abuse or neglect;

(3) A member of the state legislature when necessary to carry out that member's official duties; and

(4) Any other individuals ordered by an administrative law judge or judge of a court of competent jurisdiction.

(c) Notwithstanding any other provision in this chapter, CCL staff, in consultation with the Office of the General Counsel, may withhold any information in its records if the release of that information would endanger the life or safety of any individual.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 30, 2013.

TRD-201300363

Gerry Williams
General Counsel
Department of Family and Protective Services
Effective date: March 1, 2013
Proposal publication date: November 16, 2012
For further information, please call: (512) 438-3437

♦ ♦ ♦

CHAPTER 748. MINIMUM STANDARDS FOR GENERAL RESIDENTIAL OPERATIONS
SUBCHAPTER C. ORGANIZATION AND ADMINISTRATION
DIVISION 1. PERMIT HOLDER RESPONSIBILITIES

40 TAC §748.103

The Health and Human Services Commission adopts, on behalf of the Department of Family and Protective Services (DFPS), an amendment to §748.103 without changes to the proposed text published in the November 16, 2012, issue of the *Texas Register* (37 TexReg 9076). The justification for the amendment is to implement legislation passed during the 82nd Legislative Session. Senate Bill (S.B.) 1178, 82nd Legislature, made changes to Chapter 42 of the Human Resources Code (HRC) in regards to who is ineligible to be a controlling person at an operation regulated by Child Care Licensing (CCL). Earlier this year, CCL amended administrative rules to implement the legislation (the rules became effective March 1, 2012). These changes will further support the implementation of S.B. 1178 by outlining when an operation must report changes to CCL regarding persons who serve as a controlling person. Also, DFPS is changing the name of this chapter to Minimum Standards for General Residential Operations.

The amendment to §748.103 adds a requirement that the permit holder notify CCL when either of the following occurs: (1) a new individual becomes a controlling person at the operation; or (2) an individual ceases to be a controlling person at the operation. The purpose for this rule change is to ensure that CCL has the most current information on controlling persons at general residential operations so that CCL can comply with requirements in law and administrative rules to ensure that persons that are controlling persons at an operation are eligible to serve in that role. Additionally, this requirement currently exists in day care minimum standards. For the purpose of complying with the law and administrative rules, it is beneficial to CCL for the minimum standards for both day care and residential child-care operations to be consistent.

The amendment will function by ensuring that children will be safer in regulated child-care settings because CCL will have the most current information on controlling persons at general residential operations, ensuring that these operations do not have persons ineligible to be a controlling person serving in that role.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Human Resources Code (HRC) §40.0505 and Government Code §531.0055, which provide that the Health and Human Services Executive Commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including the Department of Family and Protective Services; and HRC §40.021, which provides that the Family and Protective Services Council shall study and make recommendations to the Executive Commissioner and the Commissioner regarding rules governing the delivery of services to persons who are served or regulated by the department.

The amendment implements HRC §§42.042, 42.062, and 42.072(c-1) and (g).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 30, 2013.

TRD-201300359
Gerry Williams
General Counsel
Department of Family and Protective Services
Effective date: March 1, 2013
Proposal publication date: November 16, 2012
For further information, please call: (512) 438-3437

♦ ♦ ♦

CHAPTER 749. MINIMUM STANDARDS FOR CHILD-PLACING AGENCIES
SUBCHAPTER C. ORGANIZATION AND ADMINISTRATION
DIVISION 1. PERMIT HOLDER RESPONSIBILITIES

40 TAC §749.103

The Health and Human Services Commission adopts, on behalf of the Department of Family and Protective Services (DFPS), an amendment to §749.103 without changes to the proposed text published in the November 16, 2012, issue of the *Texas Register* (37 TexReg 9077). The justification for the amendment is to implement legislation passed during the 82nd Legislative Session. Senate Bill (S.B.) 1178, 82nd Legislature, made changes to Chapter 42 of the Human Resources Code (HRC) in regards to who is ineligible to be a controlling person at an operation regulated by Child Care Licensing (CCL). Earlier this year, CCL amended administrative rules to implement the legislation (the rules became effective March 1, 2012). These changes will further support the implementation of S.B. 1178 by outlining when a child-placing agency must report changes to CCL regarding who serves as a controlling person. Also, DFPS is changing the name of this chapter to Minimum Standards for Child-Placing Agencies.

The amendment to §749.103 adds a requirement that the permit holder notify CCL when either of the following occurs: (1) a new individual becomes a controlling person at the child-placing agency; or (2) an individual ceases to be a controlling person at the child-placing agency. The justification for this rule change is to ensure that CCL has the most current information on controlling persons at child-placing agencies so that CCL can comply with requirements in law and administrative rules to ensure that persons that are controlling persons at a child-placing agency are eligible to serve in that role. Additionally, this requirement

currently exists in day care minimum standards. For the purpose of complying with the law and administrative rules, it is beneficial to CCL for the minimum standards for both day care operations and residential child care facilities to be consistent.

The amendment will function by ensuring that children will be safer in regulated child-care settings because CCL will have the most current information on controlling persons at child-placing agencies, ensuring that these facilities do not have persons ineligible to be a controlling person serving in that role.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Human Resources Code (HRC) §40.0505 and Government Code §531.0055, which provide that the Health and Human Services Executive Commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including the Department of Family and Protective Services; and HRC §40.021, which provides that the Family and Protective Services Council shall study and make recommendations to the Executive Commissioner and the Commissioner regarding rules governing the delivery of services to persons who are served or regulated by the department.

The amendment implements HRC §§42.042, 42.062, and 42.072(c-1) and (g).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 30, 2013.

TRD-201300360
Gerry Williams
General Counsel
Department of Family and Protective Services
Effective date: March 1, 2013
Proposal publication date: November 16, 2012
For further information, please call: (512) 438-3437

♦ ♦ ♦

CHAPTER 750. MINIMUM STANDARDS FOR INDEPENDENT FOSTER HOMES
SUBCHAPTER C. ORGANIZATION AND ADMINISTRATION
DIVISION 1. PERMIT HOLDER RESPONSIBILITIES

40 TAC §750.103

The Health and Human Services Commission adopts, on behalf of the Department of Family and Protective Services (DFPS), an amendment to §750.103 without changes to the proposed text published in the November 16, 2012, issue of the *Texas Register* (37 TexReg 9078). The justification for the amendment is to implement legislation passed during the 82nd Legislative Session. Senate Bill (S.B.) 1178, 82nd Legislature, made changes to Chapter 42 of the Human Resources Code (HRC) in regards to who is ineligible to be a controlling person at an operation regulated by Child Care Licensing (CCL). Earlier this year, CCL amended administrative rules to implement the legislation (the rules became effective March 1, 2012). These changes will further support the implementation of S.B. 1178 by outlining when an independent foster home must report changes to CCL regarding who serves as a controlling person. Also, DFPS is changing the name of this chapter to Minimum Standards for Independent Foster Homes.

The amendment to §750.103 adds a requirement that the permit holder notify CCL when either of the following occurs: (1) a new individual becomes a controlling person at the independent foster home; or (2) an individual ceases to be a controlling person at the independent foster home. This change ensures that CCL has the most current information on controlling persons at independent foster homes so that CCL can comply with requirements in law and administrative rules to ensure that persons that are controlling persons at an independent foster home are eligible to serve in that role. Additionally, this requirement currently exists in day care minimum standards. For the purpose of complying with the law and administrative rules, it is beneficial to CCL for the minimum standards for both day care operations and residential child care facilities to be consistent.

The amendment will function by ensuring that children will be safer in regulated child-care settings because CCL will have the most current information on controlling persons at independent foster homes, ensuring that these facilities do not have persons ineligible to be a controlling person serving in that role.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Human Resources Code (HRC) §40.0505 and Government Code §531.0055, which provide that the Health and Human Services Executive Commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including the Department of Family and Protective Services; and HRC §40.021, which provides that the Family and Protective Services Council shall study and make recommendations to the Executive Commissioner and the Commissioner regarding rules governing the delivery of services to persons who are served or regulated by the department.

The amendment implements HRC §§42.042, 42.062, and 42.072(c-1) and (g).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 30, 2013.

TRD-201300361
Gerry Williams
General Counsel
Department of Family and Protective Services
Effective date: March 1, 2013
Proposal publication date: November 16, 2012
For further information, please call: (512) 438-3437

♦ ♦ ♦

TITLE 43. TRANSPORTATION

PART 1. TEXAS DEPARTMENT OF TRANSPORTATION

CHAPTER 9. CONTRACT AND GRANT MANAGEMENT

SUBCHAPTER C. CONTRACTING FOR ARCHITECTURAL, ENGINEERING, AND SURVEYING SERVICES

The Texas Department of Transportation (department) adopts the repeal of §§9.30, 9.31, 9.33 - 9.39, and 9.41 - 9.43; and new §§9.30 - 9.39, concerning Subchapter C, Contracting for Architectural, Engineering, and Surveying Services. The repeal of §§9.30, 9.31, 9.33 - 9.39, and 9.41 - 9.43; and new §§9.30 - 9.32, 9.35, and 9.37 - 9.39 are adopted without changes to the proposed text as published in the November 9, 2012, issue of the *Texas Register* (37 TexReg 8944) and will not be republished. New §§9.33, 9.34, and 9.36 are adopted with changes to the proposed text as published in the November 9, 2012, issue of the *Texas Register* (37 TexReg 8944).

EXPLANATION OF ADOPTED REPEALS AND NEW SECTIONS

Architectural, engineering, and surveying services are procured by the department in accordance with Government Code, Chapter 2254, Subchapter A (Professional Services Procurement Act). The new sections reorganize the structure of the rules to follow a logical sequence of precertification, provider selection, contract negotiation, and contract administration. The new structure permits easier location of and access to the information as needed and makes the subchapter as a whole more understandable.

Substantive changes address two areas, administrative qualification and provider selection. First, the department adopts a procedure to allow providers to become administratively qualified through self-certification, in accordance with the Federal Highway Administration (FHWA) regulations. Second, the department adopts two new provider selection processes, the federal process and the small contract process.

The department requested input from FHWA and the American Council of Engineering Companies-Texas (ACEC-TX) to help formulate the new rules.

New §9.30, Purpose, is based on current §9.30. The rule is reorganized to improve understandability, and the text is revised for clarity. The text pertaining to precertification is not incorporated into new §9.30 because the topic of precertification is secondary to the overall purpose of the subchapter and precertification is addressed in new §9.33. New §9.30 includes the citations for the applicable federal laws because new §9.35 establishes a provider selection process specifically for contracts reimbursed with federal-aid highway program (FAHP) funds.

New §9.31, Definitions, is based on current §9.31. Terms deemed to be sufficiently defined elsewhere are not incorporated into the new definitions section. These terms include: "AASHTO," "administrative qualification," "available personnel," "border district," "close out," "consultant," "debarment certification," "DBE/HUB goal participation," "Disadvantaged Business Enterprise (DBE)," "department project manager," "firm," "indefinite deliverable contract," Historically Underutilized Business (HUB)," "indirect cost rate guidance," "interview contract guide (ICG)," "licensed state land surveyor," "lower tier debarment certification," "lower tier participant," "metropolitan district", "professional engineer,"; "professional services provider," "registered architect," "registered professional land surveyor," "request for proposal," "short list meeting," "specific deliverable contract," and "team." The definitions of the remaining terms are revised for clarity. New §9.31 adds seven new terms: "executive director," "non-listed category," "provider," "request for qualification," "standard work category," "statement of qualification," and "solicitation."

New §9.32, Selection Processes, Contract Types, Selection Types, and Projected Contracts, is based on current §9.39. The subsections are reorganized to improve understandability, and the text is revised for clarity. The text in current §9.39(a)(3), pertaining to emergency contracts, is not incorporated into new §9.32 because new §9.37 addresses the emergency contract process. The text of current §9.39(b)(1) pertaining to the dollar limits for indefinite deliverable contracts is also not incorporated into new §9.32. The dollar limits will instead be controlled through management directives. New §9.32(a) introduces the department's four selection types, standard process, federal process, small contract process, and emergency process.

New §9.33, Precertification, is based on current §9.41 and §9.43. The subsections are reorganized to improve understandability, and the text is revised for clarity. New §9.33(c)(3) clarifies that a firm's precertification status is only applicable to the incorporated business entity that employs the individual on whom the firm's precertification status is based and does not extend to a subsidiary, affiliate, or parent of the incorporated entity.

New §9.34, Standard Process, is based on several current subsections, detailed below. The subsections are reorganized to improve understandability, and the text is revised for clarity. It should be noted that new §9.34 encapsulates the department's core provider selection process.

New §9.34(b), pertaining to administrative qualification, is based on current §9.42. New §9.34(b)(2) clarifies that indirect cost rates must be based on entire incorporated entities and not on their individual units or divisions. New §9.34(b)(3) establishes provisions for administrative qualification through self-certification. New §9.34(b)(4) clarifies that administrative qualification is only applicable to the incorporated business entity upon which the indirect cost rate is based and does not extend to a subsidiary, affiliate, or parent of the incorporated entity.

New §9.34(c), pertaining to the consultant selection team (CST), is based on current §9.34(a). New §9.34(c)(4) clarifies that if a CST member leaves the CST, the selection process may continue subject to the professional registration requirements.

New §9.34(d), pertaining to the notice of intent (NOI), is based on current §9.33(a). Current §9.33(a)(1) - (9) is not incorporated into new §9.34 because the text is overly prescriptive for the purposes of the subchapter.

New §9.34(e), pertaining to the letter of interest (LOI), simplifies procedures by eliminating the requirements under current §9.33(b), as the text is overly prescriptive for the purposes of the subchapter.

New §9.34(f) clarifies that an individual proposed as a replacement for the prime provider project manager or a task leader must be designated in the LOI and must satisfy the applicable precertification and non-listed category requirements.

New §9.34(g), pertaining to long list qualification, is based on current §9.34(b).

New §9.34(h), pertaining to long list evaluation, is based on current §9.34(c) and (d). New §9.34(h)(1) establishes a permissive approach to the long list evaluation criteria, thereby providing greater flexibility. Also, current §9.34(e), pertaining to scoring the letters of interest, is not incorporated into new §9.34 because the text is unnecessary for the purposes of the subchapter. New §9.34(h)(2), pertaining to the short list, is based on current §9.34(f). New §9.34(h)(3), pertaining to notifying short-listed prime providers, is based on current §9.34(g).

New §9.34(i), pertaining to short list evaluation, is based on current §9.35 and §9.36. Current §9.35(a) and (b) and §9.36(a) - (c) are not incorporated into new §9.34 because the text is overly prescriptive for the purposes of the subchapter. New §9.34(i)(1)(A) clarifies that interview attendance requirements will be specified in the NOI. New §9.34(i)(2) is based on current §9.35(d) and §9.36(e). New §9.34(i)(2) establishes a permissive approach to the short list evaluation criteria, thereby providing greater flexibility.

New §9.34(j), pertaining to provider selection, is based on current §9.37. Current §9.37(a)(1) is not incorporated into new §9.34, removing the requirement for a 70/30 split in scoring interviews and proposals and providing greater flexibility. Current §9.37(b) is not incorporated into new §9.34, because new §9.34(j)(2) establishes a tie-breaking mechanism based on the relative importance factor of each short list criterion. Current §9.37(c), pertaining to selection summary, is not incorporated into new §9.34 because the text is unnecessary for the purposes of the subchapter. New §9.34(j)(3) and (4), pertaining to submittal of selection and notification, is based on current §9.37(d) and (e). New §9.34(j)(5), pertaining to an appeal, is based on current §9.37(g) and references 43 TAC §9.7, pertaining to Protest of Contract Practices or Procedures.

New §9.35, Federal Process, establishes a provider selection process for engineering or design related contracts directly related to a construction project and reimbursed with federal-aid highway program (FAHP) funds. New §9.35 is substantively similar to new §9.34, with the exception that new §9.35(b) establishes that, under the federal process, firms providing engineering and design related services must be administratively qualified, in accordance with Federal Highway Administration regulations.

New §9.36, Small Contract Process, establishes a provider selection process for architectural, engineering, or surveying services contracts that meet the following requirements: (1) the contract is not subject to the federal process; (2) the contract value does not exceed $750,000 in total; (3) the selection type is single contract; and (4) the contract type is specific deliverable. New §9.36 incorporates certain elements of the standard process, including new §9.34(b), pertaining to administrative qualification, and new §9.34(c), pertaining to the CST. A key distinction between the two processes is that the small contract process does not utilize a short list phase. The department issues a solicitation, known as a request for qualification. A provider responds by submitting a statement of qualification (SOQ). A provider is evaluated and selected solely on the information presented in its SOQ, without participating in an interview or submitting a proposal.

New §9.37, Emergency Contract Process, is based on current §9.39(a)(3). The current subsection is reorganized to improve understandability, and the current text is revised for clarity. Current §9.39(a)(3)(C), pertaining to the negotiation of emergency contracts, is not incorporated into new §9.37 because new §9.38(b) addresses this matter.

New §9.38, Negotiations, is based on current §9.37(f). The current subsection is reorganized to improve understandability, and the current text is revised for clarity. Current §9.37(f)(2)(A) - (C) is not incorporated into new §9.38 because the text is overly prescriptive for the purposes of the subchapter. Current §9.37(g), pertaining to appealing the selection process, is not incorporated into new §9.38 because new §9.34(j)(5) addresses this matter. New §9.38(a) establishes the negotiations requirements for contracts subject to the standard, federal, and small contract processes. New §9.38(b) establishes the negotiations requirements for contracts subject to the emergency contract process. New §9.38(c) establishes the negotiations requirements for indefinite deliverable work authorizations.

New §9.39, Contract Administration, is based on current §9.38. The current subsections are reorganized to improve understandability, and the current text is revised for clarity. Current §9.38(b)(1)(A) and (B), pertaining to the department project manager and prime provider project manager, are not incorporated into new §9.39 because the text is unnecessary for the purposes of the subchapter. Similarly, current §9.38(c), pertaining to supplemental agreements, and §9.38(e), pertaining to contract close out, are not incorporated into new §9.39. Current §9.38(d), pertaining to indefinite deliverable work authorization negotiation is not incorporated into new §9.39 because new §9.38(c) addresses this matter.

COMMENTS

Comments were received from Steve Stagner of ACEC-TX.

Comment: Section 9.34(g)(1) provides that the department may disqualify an LOI if the department has knowledge that a firm or an employee has a record of unprofessional conduct. This provision is overly vague and provides no due process. ACEC-TX suggests that any disqualification be tied to the department's existing process for sanctions.

Response: Sections 9.33(e)(2)(D), 9.34(g)(1), and 9.36(g)(1) are modified to clarify their original intent. Under §9.34(g)(1), as changed in response to the comment, the department may disqualify an LOI if the department has knowledge that a firm or employee, after the exhaustion of available appeals, has been determined by a state licensing entity or a court to have violated a statute or rule of the licensing entity related to occupational or professional conduct. Additionally, provisions in §9.33(e)(2)(D) and §9.36(g)(1) that are similar to §9.34(g)(1) have been changed for clarity and consistency.

Comment: Section 9.34(i)(2)(E) provides that one of the short-list evaluation criteria is the provider's past performance scores in the department's CCIS database that reflect less than satisfactory performance. Ideally, past performance with the department is important but ACEC-TX has concerns about how valid, complete, and useful this database is given the lack of consistency and universality. ACEC-TX suggests that the current database should not be used and that this provision should be deleted. If it is to be used, there should be some clarification of how the database will be used. If a project manager was with a different firm and received a satisfactory score but the firm received a less than satisfactory one, how will that be considered? Will the proposing firm be allowed to offer a rebuttal and how will that be considered?

Response: The department intends to maintain §9.34(i)(2)(E) as proposed, as the evaluation of performance is required under the federal Brooks Act and 23 C.F.R. §172. However, ACEC-TX's concern regarding consistency and universality is understandable. To address this concern, the department is developing a software application that calculates an average score for each project manager and each firm based on individual evaluations in the CCIS database. The scoring methodology will be applied universally, across the database. Also, firms and project managers will continue to be scored independently of each other; a firm's past performance is not a factor in a project manager's score, and vice versa. For a given pairing, the software application will combine the firm's and project manager's scores to generate a composite score. This composite score will be applied by the consultant selection team during the short list stage of the selection process.

Comment: ACEC-TX suggests that the proposed rules be amended in sections relating to the consultant selection team to require that CST members be from the district in which the project is located. These members will better understand key project issues.

Response: The department intends to maintain §9.34(c) as proposed. On average, for contracts utilized by districts, district employees on CSTs outnumber non-district employees by a 2:1 ratio. CSTs have been, and will continue to be, composed of mostly district employees. Also, the department must have the flexibility to include non-district employees when necessary. While district representation is important, specialized knowledge is sometimes required. Certain selections require a level of expertise beyond that of the district. An example is specialized bridge design; for such projects, representation by the Bridge Division is required. Further, not all contracts selected under this process are utilized by districts; the department's divisions have specialized contracting needs that utilize this process.

43 TAC §§9.30, 9.31, 9.33 - 9.39, 9.41 - 9.43

STATUTORY AUTHORITY

The repeals are adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §223.041, regarding the use by the department of private sector professional services for transportation projects, and Government Code, Chapter 2254, Subchapter A (Professional Services Procurement Act), which sets forth requirements for selection and contracting of architectural and engineering services.

CROSS REFERENCE TO STATUTE

Government Code, Chapter 2254, Subchapter A (Professional Services Procurement Act) and Transportation Code, §223.041.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300418

Jeff Graham
General Counsel
Texas Department of Transportation
Effective date: February 21, 2013
Proposal publication date: November 9, 2012
For further information, please call: (512) 463-8683

♦ ♦ ♦

43 TAC §§9.30 - 9.39

STATUTORY AUTHORITY

The new sections are adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §223.041, regarding the use by the department of private sector professional services for transportation projects, and Government Code, Chapter 2254, Subchapter A (Professional Services Procurement Act), which sets forth requirements for selection and contracting of architectural and engineering services.

CROSS REFERENCE TO STATUTE

Government Code, Chapter 2254, Subchapter A (Professional Services Procurement Act) and Transportation Code, §223.041.

§9.33. Precertification.

(a) Standard work categories. Precertification establishes the minimum technical qualifications to perform work under a standard work category. The Texas Transportation Commission, by minute order, may add, revise, or delete a standard work category.

(b) Contract eligibility.

(1) To be eligible to perform work under a standard work category, a provider must have active precertification status in that work category by the closing date of the solicitation.

(2) The department will not delay the selection process or the contract execution to accommodate a provider that is not in active precertification status.

(c) Precertification status of firms and employees.

(1) A firm is precertified in a standard work category only if it employs an individual precertified in that category.

(2) A firm that employs an individual who is precertified in multiple standard work categories is, by extension, precertified in each of those categories.

(3) A firm's precertification status is only applicable to the incorporated business entity that employs the individual upon whom the firm's precertification status is based and does not extend to a subsidiary, affiliate, or parent of the incorporated entity.

(4) An employee's precertification status is based solely on the individual's qualifications. A firm's qualifications may not serve as a basis for precertifying an employee.

(5) Precertification status shall transfer with the employee, should the employee leave the firm.

(d) Precertification website. The department will maintain a precertification website that will include:

(1) the definitions of the standard work categories;

(2) the minimum technical qualifications to perform work under the standard work categories; and

(3) the precertification application form, with instructions.

(e) Application and review process.

(1) To apply for precertification in a standard work category, a firm must employ an individual qualified to become precertified in that category and present the individual's qualifications in a precertification application.

(2) The department will consider the following factors in reviewing an application:

(A) the minimum technical qualifications as applicable;

(B) the individual's professional license or registration;

(C) the individual's experience and training; and

(D) any record that shows that the individual or the firm is the subject of a final administrative or judicial determination that the employee or firm has violated a statute or rule of a state licensing entity related to occupational or professional conduct.

(3) If a submitted application is incomplete or inaccurate, the firm will be given an opportunity to correct the application and provide additional information. The firm must provide the information within 30 days after the day that it receives the department's notice that the application is incomplete or inaccurate.

(4) If the information is not provided under paragraph (3) of this subsection within the 30-day period prescribed by that paragraph, the application will be processed at the end of that 30-day period with the information available.

(5) The department will make a good faith effort to make a precertification determination within 60 days after the day that the department receives a complete and accurate application or if paragraph (4) of this subsection applies, within 60 days after the day that the 30-day period prescribed by that paragraph ends.

(f) Appeal. A firm may appeal a precertification denial to the Design Division by submitting additional information within 30 days after the day that it receives written notification of the denial. The information must justify why precertification should be granted. The department will review the information and make a second precertification determination. A firm may file a written complaint regarding a second precertification denial to the executive director or the executive director's designee.

(g) Updates. A firm must report any change in its application information no later than 45 days after the day that the change occurs.

(h) Data management. A firm's application information will be maintained in the CCIS.

(i) Annual renewal. To maintain contract eligibility, a firm must renew its precertification status no later than March 31 of each year. The firm must submit its annual renewal through the CCIS.

(1) A firm that has renewed its precertification status by the annual deadline will maintain an active precertification status in the standard work categories in which it is precertified.

(2) A firm that has not renewed its precertification by the annual deadline will be placed in inactive status.

§9.34. Standard Process.

(a) Applicability. The standard process, described under this section, may be used for any architectural, engineering, or surveying services contract not subject to §9.35 of this subchapter (relating to Federal Process).

(b) Administrative qualification.

(1) Administrative qualification is a process used by the department to verify that a provider has an indirect cost rate that meets department requirements. Except as provided by paragraph (8) of this subsection, to compete for a contract under this section a provider either must be administratively qualified or must accept an indirect cost rate under paragraph (7) of this subsection.

(2) Factors in determining administrative qualification.

(A) A provider may demonstrate administrative qualification by an audit or by self-certification of its incorporated entity. Indirect cost rates must be based on the entire incorporated entity and may not be based on the entity's units or divisions.

(i) An audit may be performed by an independent certified public accountant (CPA), an agency of the federal government, another state transportation agency, or a local transit agency. An audit performed by an independent CPA must be conducted in accordance with the current versions of 48 C.F.R. Part 31, the Generally Accepted Government Auditing Standards (GAGAS), and the American Association of State Highway Transportation Officials (AASHTO) Uniform Audit and Accounting Guide. The provider must provide the department with unrestricted access to the audit work papers, records, and other information as requested by the Audit Office.

(ii) Self-certification may be conducted by the provider and must include a cost report and an internal controls report. The self-certified cost report must comply with the current versions of 48 C.F.R. Part 31, the GAGAS, and the AASHTO Uniform Audit and Accounting Guide. The self-certified internal control report must certify the provider has internal controls in place within its organization. Both the cost report and the internal control report must be signed by a company officer and notarized.

(B) The audit or self-certification shall be based on the provider's fiscal year. The indirect cost rate, as approved by the Audit Office, shall become effective six months after the end of the provider's fiscal year, or immediately if filed more than six months after the end of the provider's fiscal year. It shall be effective no more than twelve months and shall expire eighteen months after the end of the fiscal year upon which it is based.

(C) A provider must submit on an annual basis a compensation analysis for all executives in accordance with the AASHTO Uniform Audit and Accounting Guide.

(D) The department may audit the indirect cost rate of a provider under contract with, or seeking to do business with, the department. These audits will be conducted in accordance with the criteria outlined in this subsection.

(E) A provider must submit a signed Certification of Final Indirect Costs with the audit report or self-certification. The certification must follow the requirements of the Federal Highway Administration.

(3) Submittal and review process for administrative qualification.

(A) A provider must submit its administrative qualification information to the Audit Office in accordance with the instructions on the department's website. Administrative qualification submittals will not be received by the Design Division.

(B) Upon review of an audit report or self-certification received from a provider, the Audit Office may request additional information from the provider. If the submittal is not complete and accurate, the Audit Office will return it to the provider for correction. Upon request for additional information by the Audit Office, the provider shall submit the information within 15 days after the day that it receives the

Audit Office's request. If the information is not provided within the 15-day period, the submittal will be placed on pending status for an additional 15 days. If the information is not received within the additional 15-day period, the submittal will not be processed for administrative qualification.

(4) Administrative qualification is applicable only to the incorporated business entity upon which the indirect cost rate is based and does not extend to a subsidiary, affiliate, or parent of the incorporated entity.

(5) The Audit Office will provide a selected firm's indirect cost rate information to the managing office on notification from the Design Division, for use in negotiations under §9.38 of this subchapter (relating to Negotiations).

(6) The Audit Office will not provide a firm's administrative qualification information to the managing office or the consultant selection team before the selection of that firm.

(7) Providers not administratively qualified. The department may contract with a prime provider or allow the use of a subprovider that is not administratively qualified if:

(A) the provider has been in operation, as currently organized, for less than one fiscal year and the provider accepts an indirect cost rate developed by the Audit Office; or

(B) on request by the department during the selection process, the prime provider provides written certification that the prime provider or subprovider, as applicable, does not have an indirect cost rate audit and will accept an indirect cost rate developed by the Audit Office.

(8) Exemptions to administrative qualification.

(A) A non-engineering firm is exempt from the administrative qualification requirement of this section.

(B) A provider performing a service under standard work category 18.2.1, subsurface utilities engineering, or any of the following work groups, as listed on the department's precertification website, is exempted from administrative qualification, to the extent of the service being performed:

(i) Group 6, bridge inspection;

(ii) Group 12, materials inspection and testing;

(iii) Group 14, geotechnical services;

(iv) Group 15, surveying and mapping; and

(v) Group 16, architecture.

(C) The Audit Office and Design Division may exempt services other than those indicated in subparagraph (B) of this paragraph on a case-by-case basis. Any request for an exemption must be received by the Audit Office by the closing date of the solicitation.

(c) Consultant selection team (CST).

(1) The department shall use a CST in selecting providers under this section.

(2) The CST shall be composed of the department employee designated as the CST chair, the department employee designated as the project manager, and at least one other department employee.

(3) At least one CST member must be a professional engineer, for engineering contracts; a registered architect, for architectural contracts; and either a professional engineer or registered professional land surveyor, for surveying contracts.

(4) If a CST member leaves the CST during the selection process, the process may continue with the remaining members, subject to paragraph (3) of this subsection.

(d) Notice of intent (NOI). Not fewer than 21 calendar days before the solicitation closing date, the department will post on a web-based bulletin board an NOI providing the contract information and specifying the requirements for preparing and submitting a letter of interest.

(e) Letter of interest (LOI). To be considered, an LOI must comply with the requirements specified in the NOI.

(f) Replacements. An individual proposed as a replacement for the prime provider project manager or a task leader must be designated in the LOI and must satisfy the applicable precertification and NLC requirements.

(g) Long list qualification.

(1) The department may disqualify an LOI if the department has knowledge that a firm on the project team or an employee of a firm on the project team is the subject of a final administrative or judicial determination that the firm or employee has violated a statute or rule of a state licensing entity related to occupational or professional conduct.

(2) If an LOI is not disqualified under paragraph (1) of this subsection, the CST will screen the LOI to determine whether it complies with the requirements specified in the NOI. Each LOI that meets these requirements will be considered responsive to the NOI, placed on a long list, and evaluated.

(h) Long list evaluation.

(1) Long list evaluation criteria. The CST will evaluate the long-listed LOIs to establish a short list according to the long list evaluation criteria specified in the NOI. These criteria may include:

(A) project understanding and approach;

(B) project manager's experience with similar projects;

(C) similar project related experience of the task leaders responsible for the major work categories identified in the NOI; and

(D) other qualifications-based criteria approved by the Design Division.

(2) Short list. The short list will consist of the most qualified providers, as indicated by the long list scores.

(A) For single contract selections, the minimum number of short-listed prime providers is three, unless fewer than three prime providers submitted responsive LOIs.

(B) For multiple contract selections, the minimum number of short-listed prime providers is the number of desired contracts plus three, unless fewer than the desired number of prime providers submitted responsive LOIs.

(3) Notification.

(A) The department will notify each prime provider that submitted an LOI whether it was short-listed.

(B) The department will notify each short-listed prime provider whether a short list meeting will be held.

(i) Short list evaluation.

(1) Interviews and proposals. The department will evaluate the short-listed providers through interviews, proposals, or both.

(A) For interviews, the department will issue an Interview and Contract Guide (ICG) to each short-listed prime provider. The ICG will provide contract information and specify the requirements for the interview. Any requirements pertaining to interview attendance will be specified in the NOI.

(B) For proposals, the department will issue a Request for Proposal (RFP) to each short-listed prime provider. The RFP will provide contract information and specify the requirements for the preparation and submittal of a proposal.

(2) Short list evaluation criteria. The CST will evaluate the interviews and proposals according to the short list evaluation criteria specified in the ICG and RFP. These criteria may include:

(A) understanding of the scope of services;

(B) experience of the project manager and project team;

(C) ability to meet the project schedule;

(D) prime provider's quality assurance/quality control program;

(E) prime provider's past performance scores in the CCIS database for department contracts reflecting less than satisfactory performance; and

(F) other qualifications-based criteria approved by the Design Division.

(j) Selection.

(1) Basis of final selection. The CST will select the best qualified provider, as indicated by the short list scores.

(2) Tie scores. The managing officer will break a tie using the following method.

(A) Interviews only.

(i) The first tie breaker will be the scores for the interview criterion with the highest RIF.

(ii) The remaining interview criteria shall be compared in the order of decreasing RIF until the tie is broken.

(iii) If the providers have identical scores on all of the interview criteria, the provider will be chosen by random selection.

(B) Proposals only.

(i) The first tie breaker will be the scores for the proposal criterion with the highest RIF.

(ii) The remaining proposal criteria shall be compared in the order of decreasing RIF until the tie is broken.

(iii) If the providers have identical scores on all of the proposal criteria, the provider will be chosen by random selection.

(C) Interviews and proposals, both.

(i) If the interviews are weighted at 50 percent or more of the short list score, subparagraph (A)(i) and (ii) of this paragraph applies. If the providers have identical scores on all of the interview criteria, subparagraph (B)(i) - (iii) of this paragraph applies.

(ii) If the proposals are weighted at more than 50 percent of the short list score, subparagraph (B)(i) and (ii) of this paragraph applies. If the providers have identical scores on all of the proposal criteria, subparagraph (A)(i) - (iii) of this paragraph applies.

(D) Order of comparison. If the interview or proposal criteria have equal RIFs, the criteria will be compared in the order listed in the ICG or RFP.

(3) Submittal of selection. The managing officer will submit the evaluation documentation and recommendation for selection to the Design Division director for review. If the procedural review is acceptable, the executive director or the executive director's designee will concur with the selection.

(4) Notification. The department will:

(A) provide written notification to the prime provider selected for contract negotiation and arrange a meeting to begin contract negotiations;

(B) provide written notification to each short-listed prime provider that was not selected, notifying the provider of the non-selection; and

(C) publish the short list and the selected provider on a web-based bulletin board.

(5) Appeal. A provider may file a written appeal concerning the selection process with the executive director or the executive director's designee as provided under §9.7 of this chapter (relating to Protest of Contract Practices or Procedures).

§9.36. Small Contract Process.

(a) Applicability. The small contract process described under this section may be used for an architectural, engineering, or surveying services contract that meets the following requirements:

(1) the contract is not subject to §9.35 of this subchapter (relating to Federal Process);

(2) the contract value does not exceed $750,000 in total;

(3) the selection type is single contract; and

(4) the contract type is specific deliverable.

(b) Administrative qualification. Section 9.34(b) of this subchapter (relating to Standard Process) applies to contracts under this section.

(c) Consultant selection team. Section 9.34(c) of this subchapter applies to contracts under this section.

(d) Request for qualifications (RFQ). Not fewer than 14 calendar days before the solicitation closing date, the department will post on a web-based bulletin board an RFQ providing the contract information and specifying the requirements for preparing and submitting a statement of qualification.

(e) Statement of qualification (SOQ). To be considered, an SOQ must comply with the requirements specified in the RFQ.

(f) Replacements. An individual proposed as a replacement for the prime provider project manager or a task leader must be designated in the SOQ and must satisfy the applicable precertification and NLC requirements.

(g) Qualification for evaluation.

(1) The department may disqualify an SOQ if the department has knowledge that a firm on the project team or an employee of a firm on the project team is the subject of a final administrative or judicial determination that the firm or employee has violated a statute or rule of a state licensing entity related to occupational or professional conduct.

(2) If an SOQ is not disqualified under paragraph (1) of this subsection, the CST will screen the SOQ to determine whether it complies with the requirements specified in the RFQ. Each SOQ that meets these requirements will be considered responsive to the RFQ and evaluated.

(h) SOQ evaluation. The CST will evaluate the responsive SOQs according to the following selection criteria specified in the RFQ. These criteria may include:

(1) project understanding and approach;

(2) the prime provider project manager's experience with similar projects;

(3) similar project-related experience of the task leaders responsible for the major work categories identified in the RFQ;

(4) past performance scores in the CCIS database for department contracts reflecting less than satisfactory performance; and

(5) other qualifications-based criteria approved by the Design Division.

(i) Selection.

(1) Basis of final selection. The CST will select the best qualified provider, as indicated by the SOQ scores.

(2) Tie scores. The managing officer will break a tie using the following method.

(A) The first tie breaker is the scores for the selection criterion with the highest RIF.

(B) The remaining selection criteria will be compared in the order of decreasing RIF until the tie is broken.

(C) If the providers have identical scores on all of the selection criteria, the provider will be chosen by random selection.

(3) Submittal of selection. Section 9.34(j)(3) of this subchapter applies to this section.

(4) Notification. The department will:

(A) provide written notification to a prime provider selected for contract negotiation and arrange a meeting to begin contract negotiations;

(B) provide written notification to each prime provider that was not selected, notifying the provider of the non-selection; and

(C) publish the selected provider on a web-based bulletin board.

(5) Appeal. Section 9.34(j)(5) of this subchapter applies to this section.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300419
Jeff Graham
General Counsel
Texas Department of Transportation
Effective date: February 21, 2013
Proposal publication date: November 9, 2012
For further information, please call: (512) 463-8683

♦ ♦ ♦

CHAPTER 12. PUBLIC DONATION AND PARTICIPATION PROGRAM

SUBCHAPTER K. ACKNOWLEDGMENT PROGRAM

43 TAC §§12.351 - 12.355

The Texas Department of Transportation (department) adopts new Subchapter K, §§12.351 - 12.355, concerning the Acknowledgment Program. New §§12.351 - 12.355 are adopted without changes to the proposed text as published in the November 9, 2012, issue of the *Texas Register* (37 TexReg 8952) and will not be republished.

EXPLANATION OF ADOPTED NEW SECTIONS

New Subchapter K provides for a state acknowledgement program that will allow the department to place signs to acknowledge the acceptance of donations under Transportation Code, §201.206 for transportation services, such as mowing, litter and debris pick-up on the state's right of way, maintenance services for safety rest areas, toll gantry facilities, and Travel Information Centers.

Federal law generally prohibits advertisement in the state right of way. However, the Federal Highway Administration (FHWA) released new guidelines on March 13, 2012 allowing the use of sponsorship acknowledgement signs on state right of way. The new guidelines allow the use of business logos and emblems that were not originally allowed under the Adopt-a-Highway program. Through the new guidelines, FHWA has recognized a distinction between advertisements and acknowledgement signs. The guidelines provide the state the opportunity to acknowledge donations made by business entities through acknowledgement signs. The new guidelines limit the sign to recognition of the donation of a transportation service and prohibit the inclusion of any contact or location information.

The department may solicit proposals for one or more professional service vendors to market, administer, recruit, and secure sponsors for the program at no cost to the department. Under the program a participating sponsor will be recognized with an acknowledgment sign near the location for which the services are being provided.

New §12.351, Purpose, states that the new subchapter authorizes the acknowledgement program and provides the general information about the program.

New §12.352, Definitions, provides the definitions for terms used within the subchapter. The terms are defined to provide a clear understanding of their usage within the subchapter.

New §12.353, Acknowledgement Program, authorizes the department to develop an acknowledgement program. The program will allow the recognition of monetary donations for highway-related purposes, as determined by the department and as required by the applicable federal guidelines. The section provides the basic program requirements, which comply with FHWA guidelines.

New §12.353 provides that the department may contract under §12.354 with one or more vendors to provide the marketing services and, if so, the department will continue to provide the transportation service and sign installation. This allows the department to use an outside source for the parts of the program for which the department has limited expertise but to maintain control over the services that the department routinely handles. This will allow the greatest part of the funds to go toward the service by reducing administrative costs of the vendor.

New §12.353(g) prohibits the acceptance of donations from entities that are regulated by the department or that are involved in a contract, purchase, payment, or claim. This language allows for consistency with the current donation program. Subsection (h) prohibits an acknowledgement sign's reference to an alcoholic beverage, tobacco product, or sexually-oriented business. This maintains consistency with other department programs as these restrictions are also placed on advertisement in the *Texas Highways* magazine.

New §12.354, Acknowledgement Program Vendor Contract; Program Agreement, provides the requirements for the contract with the vendor. The section allows the department to contract with one or more vendors to provide the marketing services. It places specific requirements on the vendor's contract with the participating sponsors. These requirements ensure that the program complies with the federal guidelines. The vendor must maintain sponsor information and provide monthly and annual reports to the department. This will eliminate duplicative work by allowing the department to rely on the vendor's data. The vendor is responsible for notifying the participating sponsor if the sign must be relocated due to the need for a regulatory, warning, or guide sign. A delay in relocating the sign may result in the extension of the associated participation agreement, so that the participating sponsor receives a posted sign for the full time authorized by the agreement.

New §12.355, Acknowledgement Sign, provides the requirements for the acknowledgement signs. The sign must comply with the Texas Manual on Uniform Traffic Control Devices (TMUTCD), which regulates the size and format of the sign. The section also states that regulatory, warning, and guidance signs have priority over an acknowledgement sign. The TMUTCD has been adopted by the Texas Transportation Commission. The TMUTCD expressly provides requirements for acknowledgement signs, which cannot be changed without amendment of the manual by commission rule. Restatement of the specific sign requirements in this subchapter is unnecessary.

To comply with FHWA guidelines §12.355 requires that the sign be placed near the site for which the donation was offered, and prohibits the location of an acknowledgment sign within one mile of another acknowledgment sign if the signs are facing the same direction and associated with the same highway-related purpose. The section also gives specific guidance for signs in the rest area and travel information centers. The requirements of this section mirror FHWA guidelines, which must be included in the department's program.

COMMENTS

No comments on the proposed new sections were received.

STATUTORY AUTHORITY

The new sections are adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the department.

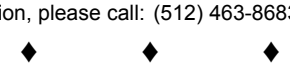
CROSS REFERENCE TO STATUTE

Transportation Code, §201.206.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 1, 2013.

TRD-201300420
Jeff Graham
General Counsel
Texas Department of Transportation
Effective date: February 21, 2013
Proposal publication date: November 9, 2012
For further information, please call: (512) 463-8683



REVIEW OF AGENCY RULES

This section contains notices of state agency rules review as directed by the Texas Government Code, §2001.039. Included here are (1) notices of *plan to review;* (2) notices of *intention to review,* which invite public comment to specified rules; and (3) notices of *readoption,* which summarize public comment to specified rules. The complete text of an agency's *plan to review* is available after it is filed with the Secretary of State on the Secretary of State's web site (http://www.sos.state.tx.us/texreg). The complete text of an agency's rule being reviewed and considered for *readoption* is available in the *Texas Administrative* Code on the web site (http://www.sos.state.tx.us/tac).

For questions about the content and subject matter of rules, please contact the state agency that is reviewing the rules. Questions about the web site and printed copies of these notices may be directed to the *Texas Register* office.

Proposed Rule Reviews

Texas Board of Nursing

Title 22, Part 11

In accordance with Government Code §2001.039, the Texas Board of Nursing (Board) files this notice of intention to review and consider for readoption, readoption with amendments, or repeal the following chapters contained in Title 22, Part 11, of the Texas Administrative Code:

Chapter 214, Vocational Nursing Education, §§214.1 - 214.13.

Chapter 215, Professional Nursing Education, §§215.1 - 215.13.

Chapter 222, Advanced Practice Registered Nurses with Prescriptive Authority, §§222.1 - 222.12.

In conducting its review, the Board will assess whether the reasons for originally adopting these chapters continue to exist. Each section of these chapters will be reviewed to determine whether it is obsolete, whether it reflects current legal and policy considerations and current procedures and practices of the Board, and whether it is in compliance with Chapter 2001 of the Government Code (the Administrative Procedure Act).

The public has thirty (30) days from the publication of this rule review notice in the *Texas Register* to comment and submit any response or suggestions. No action is required by the Board. Written comments may be submitted to Lance Brenton, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Suite 3-460, Austin, Texas 78701, by e-mail to lance.brenton@bon.texas.gov, or by fax to Lance Brenton at (512) 305-8101. Any proposed changes to the rules as a result of this review will be published separately in the Proposed Rules section of the *Texas Register* and will be open for an additional comment period prior to the final adoption or repeal by the Board.

This rule review is undertaken pursuant to the Board's 2011-2013 rule review plan that is available on the Secretary of State's website.

TRD-201300427
Lance Brenton
Assistant General Counsel
Texas Board of Nursing
Filed: February 1, 2013

♦ ♦ ♦

Adopted Rule Reviews

State Board of Dental Examiners

Title 22, Part 5

The State Board of Dental Examiners has completed its review and re-adopts without amendment Chapter 104, relating to Continuing Education. This review was done pursuant to Texas Government Code §2001.039. The notice of review was published in the December 7, 2012, issue of the *Texas Register* (37 TexReg 9659).

Texas Government Code §2001.039 requires agencies to review and consider for re-adoption each of their rules every four years. The review assesses whether the original reasons for adopting the rules continue to exist. The SBDE reviewed each section of Chapter 104 and determined that the original justification for the rules continues to exist.

No comments were received in response to the proposed rule review.

TRD-201300437
Glenn Parker
Executive Director
State Board of Dental Examiners
Filed: February 4, 2013

♦ ♦ ♦

The State Board of Dental Examiners has completed its review and re-adopts without amendment Chapter 113, relating to Requirements for Dental Offices. This review was done pursuant to Texas Government Code §2001.039. The notice of review was published in the December 7, 2012, issue of the *Texas Register* (37 TexReg 9659).

Texas Government Code §2001.039 requires agencies to review and consider for re-adoption each of their rules every four years. The review assesses whether the original reasons for adopting the rules continue to exist. The SBDE reviewed each section of Chapter 113 and determined that the original justification for the rules continues to exist.

No comments were received in response to the proposed rule review.

TRD-201300438
Glenn Parker
Executive Director
State Board of Dental Examiners
Filed: February 4, 2013

♦ ♦ ♦

Texas Education Agency

Title 19, Part 2

The State Board of Education (SBOE) adopts the review of 19 TAC Chapter 30, Administration, Subchapter A, State Board of Education: General Provisions, and Subchapter B, State Board of Education:

Purchasing and Contracts, pursuant to the Texas Government Code, §2001.039. The SBOE proposed the review of 19 TAC Chapter 30, Subchapters A and B, in the December 7, 2012, issue of the *Texas Register* (37 TexReg 9659).

The SBOE finds that the reasons for adopting 19 TAC Chapter 30, Subchapters A and B, continue to exist and readopts the rules. The SBOE received no comments related to the review of Subchapters A and B. No changes are necessary as a result of the review.

TRD-201300491
Cristina De La Fuente-Valadez
Director, Rulemaking
Texas Education Agency
Filed: February 6, 2013

♦ ♦ ♦

Texas Department of Insurance, Division of Workers' Compensation

Title 28, Part 2

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) has completed its review required by the Texas Government Code §2001.039 of the following chapter of the Texas Administrative Code, Title 28, Part 2: Chapter 49, Procedures for Formal Hearings by the Board. The reviewed sections in this chapter are subsequently referred to collectively in this Notice of Adopted Review as "the sections."

The notice of proposed rule review was published in the November 2, 2012, issue of the *Texas Register* (37 TexReg 8859). As provided in this notice, the Division reviewed and considered the sections for readoption, revision, or repeal.

The Division considered whether the reasons for adoption of the sections continue to exist.

The Division received no comments.

The Division has determined that the reasons for adopting the sections continue to exist and the sections are retained in their present form. Any revisions in the future will be accomplished in accordance with the Administrative Procedure Act.

This concludes the Division's review of Chapter 49. The completion of the review of this chapter concludes the rule review process.

TRD-201300456
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Filed: February 5, 2013

♦ ♦ ♦

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) has completed its review required by the Texas Government Code §2001.039 of the following chapter of the Texas Administrative Code, Title 28, Part 2: Chapter 116, General Provisions--Subsequent Injury Fund. The reviewed sections in this chapter are subsequently referred to collectively in this Notice of Adopted Review as "the sections."

The notice of proposed rule review was published in the November 2, 2012, issue of the *Texas Register* (37 TexReg 8860). As provided in this notice, the Division reviewed and considered the sections for readoption, revision, or repeal.

The Division considered whether the reasons for adoption of the sections continue to exist.

The Division received no comments.

The Division has determined that the reasons for adopting the sections continue to exist and the sections are retained in their present form. Any revisions in the future will be accomplished in accordance with the Administrative Procedure Act.

This concludes the Division's review of Chapter 116. The completion of the review of this chapter concludes the rule review process.

TRD-201300457
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Filed: February 5, 2013

♦ ♦ ♦

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) has completed its review required by the Texas Government Code §2001.039 of the following chapter of the Texas Administrative Code (TAC), Title 28, Part 2: Chapter 180, Monitoring and Enforcement. The reviewed sections in this chapter are subsequently referred to collectively in this Notice of Adopted Review as "the sections."

The notice of proposed rule review was published in the August 24, 2012, issue of the *Texas Register* (37 TexReg 6702). Since this notice of proposal was published, 28 TAC §180.21, Division Designated Doctor List, was repealed in a separate rulemaking activity in accordance with the Administrative Procedure Act, Government Code Chapter 2001, effective September 1, 2012. As provided in this notice, the Division reviewed and considered the sections for readoption, revision, or repeal.

The Division considered whether the reasons for adoption of the sections continue to exist. The Division received no written comments regarding the review of the sections.

As a result of the review, the Division has determined that the reasons for adoption of the sections continue to exist. The Division readopts the sections.

This concludes and completes the Division's review of Chapter 180; the chapter will be reviewed again in the future in accordance with Government Code §2001.039.

TRD-201300458
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Filed: February 5, 2013

♦ ♦ ♦

Texas Department of Transportation

Title 43, Part 1

The Texas Department of Transportation (department) files notice of the completion of review and the readoption of 43 TAC Part 1, Chapter 2, Environmental Review of Transportation Projects, and Chapter 7, Rail Facilities.

Independent of this review, the commission contemporaneously proposed amendments to, repeals of, or new sections, as published elsewhere in this issue of the *Texas Register:* §2.12, Project Coordination; §2.21, Purpose; §2.22, Memorandum of Understanding

with the Texas Parks and Wildlife Department; §2.23, Memorandum of Understanding with the Texas Natural Resource Conservation Commission; §2.24, Memorandum of Understanding with the Texas Historical Commission; §2.103, Public Participation for an Environmental Impact Statement or Supplemental Environmental Impact Statement; §§2.201 - 2.214, Memorandum of Understanding with the Texas Parks and Wildlife Department; §§2.251 - 2.278, Memorandum of Understanding with the Texas Historical Commission; §§2.301 - 2.308, Memorandum of Understanding with the Texas Commission on Environmental Quality; and §7.31, Safety Requirements.

This review and readoption have been conducted in accordance with Government Code, §2001.039. The department has reviewed these rules and received no comments on the proposed rule review, which was published in the December 7, 2012, issue of the *Texas Register* (37 TexReg 9660). The Texas Transportation Commission has determined that the reasons for adopting the specified rules continue to exist.

This concludes the review of Chapters 2 and 7.

TRD-201300413
Jeff Graham
General Counsel
Texas Department of Transportation
Filed: February 1, 2013

Graphic images included in rules are published separately in this tables and graphics section. Graphic images are arranged in this section in the following order: Title Number, Part Number, Chapter Number and Section Number.

Graphic images are indicated in the text of the emergency, proposed, and adopted rules by the following tag: the word "Figure" followed by the TAC citation, rule number, and the appropriate subsection, paragraph, subparagraph, and so on.

Figure: 16 TAC §3.13(c)(1)(B)(i)

Proposed Total Vertical Depth of Well	Surface
to 7,000 feet	25% of proposed total depth of well
7,000 - 10,000 feet	2,000 feet
10,000 and below	2,500 feet

Figure: 22 TAC §108.56(b)

For example:

Jane Doe, DDS, General Dentist
FAAD, Fellow Anytown Academy of Dentistry

OR

John Doe, DDS, General Dentist
MACD, Master Anytown College of Dentists

Figure: 28 TAC §3.3705(f)(1)

Texas Department of Insurance Notice

- *You have the right to an adequate network of preferred providers (also known as "network providers").*
    - *If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.*
    - *If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.*

- *You have the right, in most cases, to obtain estimates in advance:*
    - *from out-of-network providers of what they will charge for their services; and*
    - *from your insurer of what it will pay for the services.*

- *You may obtain a current directory of preferred providers at the following website:* [website address to be filled out by the insurer or marked inapplicable if the insurer does not maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by current or prospective insureds or group contract holders] *or by calling* [to be filled out by the insurer] *for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.*

- *If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.*

- *If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than $1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.*

Figure: 28 TAC §3.3705(f)(2)

Texas Department of Insurance Notice

- *An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy and below.*

- *You have the right to an adequate network of preferred providers (known as "network providers").*
    - *If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.*

- *If your insurer approves a referral for out-of-network services because no preferred provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the nonpreferred provider's bill so that you only have to pay any applicable coinsurance, copay, and deductible amounts.*

- *You may obtain a current directory of preferred providers at the following website:* [website address to be filled out by the insurer or marked inapplicable if the insurer does not maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by current or prospective insureds or group contract holders] *or by calling* [to be filled out by the insurer] *for assistance in finding available preferred providers. If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.*

The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Office of the Attorney General

Child Support Guidelines - 2013 Tax Charts

Pursuant to §154.061(b) of the Texas Family Code, the Office of the Attorney General of Texas, as the Title IV-D agency, has promulgated the following tax charts to assist courts in establishing the amount of a child support order. These tax charts are applicable to employed and self-employed persons in computing net monthly income.

INSTRUCTIONS FOR USE

To use these tables, first compute the obligor's annual gross income. Then recompute to determine the obligor's average monthly gross income. These tables provide a method for calculating "monthly net income" for child support purposes, subtracting from monthly gross income the social security taxes and the federal income tax withholding for a single person claiming one personal exemption and the standard deduction.

Thereafter, in many cases the guidelines call for a number of additional steps to complete the necessary calculations. For example, §§154.061 - 154.070 provide for appropriate additions to "income" as that term is defined for federal income tax purposes, and for certain subtractions from monthly net income, in order to arrive at the net resources of the obligor available for child support purposes. If necessary, one may compute an obligee's net resources using similar steps.

Note regarding Texas Family Code §154.125:

Texas Family Code §154.125 provides "The guidelines for the support of a child in this section are specifically designed to apply to situations in which the obligor's monthly net resources are not greater than $7,500 or the adjusted amount determined under Subsection (a-1), whichever is greater."

On September 1, 2013 the $7,500 amount will be adjusted as required by Texas Family Code §154.125. Before September 1, 2013 the Office of the Attorney General shall publish the adjusted amount in the *Texas Register.* These charts will be revised and republished with a September 1, 2013 effective date showing the point where Monthly Gross Wages (Employed Persons) or Monthly Net Earnings From Self-Employment (Self Employed Persons) would result in the adjusted amount of net resources.

This agency hereby certifies that the tax charts have been reviewed by legal counsel and found to be within the agency's authority to publish.

EMPLOYED PERSONS
2013 TAX CHART

Monthly Gross Wages	Social Security Taxes: Old-Age, Survivors and Disability Insurance Taxes (6.2%)*	Social Security Taxes: Hospital (Medicare) Insurance Taxes (1.45%)*,**	Federal Income Taxes***	Net Monthly Income
$100.00	$6.20	$1.45	$0.00	$92.35
$200.00	$12.40	$2.90	$0.00	$184.70
$300.00	$18.60	$4.35	$0.00	$277.05
$400.00	$24.80	$5.80	$0.00	$369.40
$500.00	$31.00	$7.25	$0.00	$461.75
$600.00	$37.20	$8.70	$0.00	$554.10
$700.00	$43.40	$10.15	$0.00	$646.45
$800.00	$49.60	$11.60	$0.00	$738.80
$900.00	$55.80	$13.05	$6.67	$824.48
$1,000.00	$62.00	$14.50	$16.67	$906.83
$1,100.00	$68.20	$15.95	$26.67	$989.18
$1,200.00	$74.40	$17.40	$36.67	$1,071.53
$1,256.67****	$77.91	$18.22	$42.33	$1,118.21
$1,300.00	$80.60	$18.85	$46.67	$1,153.88
$1,400.00	$86.80	$20.30	$56.67	$1,236.23
$1,500.00	$93.00	$21.75	$66.67	$1,318.58
$1,600.00	$99.20	$23.20	$77.81	$1,399.79
$1,700.00	$105.40	$24.65	$92.81	$1,477.14
$1,800.00	$111.60	$26.10	$107.81	$1,554.49
$1,900.00	$117.80	$27.55	$122.81	$1,631.84
$2,000.00	$124.00	$29.00	$137.81	$1,709.19
$2,100.00	$130.20	$30.45	$152.81	$1,786.54
$2,200.00	$136.40	$31.90	$167.81	$1,863.89
$2,300.00	$142.60	$33.35	$182.81	$1,941.24
$2,400.00	$148.80	$34.80	$197.81	$2,018.59
$2,500.00	$155.00	$36.25	$212.81	$2,095.94
$2,600.00	$161.20	$37.70	$227.81	$2,173.29
$2,700.00	$167.40	$39.15	$242.81	$2,250.64
$2,800.00	$173.60	$40.60	$257.81	$2,327.99
$2,900.00	$179.80	$42.05	$272.81	$2,405.34
$3,000.00	$186.00	$43.50	$287.81	$2,482.69
$3,100.00	$192.20	$44.95	$302.81	$2,560.04
$3,200.00	$198.40	$46.40	$317.81	$2,637.39
$3,300.00	$204.60	$47.85	$332.81	$2,714.74
$3,400.00	$210.80	$49.30	$347.81	$2,792.09
$3,500.00	$217.00	$50.75	$362.81	$2,869.44
$3,600.00	$223.20	$52.20	$377.81	$2,946.79
$3,700.00	$229.40	$53.65	$392.81	$3,024.14
$3,800.00	$235.60	$55.10	$407.81	$3,101.49
$3,900.00	$241.80	$56.55	$427.40	$3,174.25
$4,000.00	$248.00	$58.00	$452.40	$3,241.60
$4,250.00	$263.50	$61.63	$514.90	$3,409.97
$4,500.00	$279.00	$65.25	$577.40	$3,578.35
$4,750.00	$294.50	$68.88	$639.90	$3,746.72
$5,000.00	$310.00	$72.50	$702.40	$3,915.10
$5,250.00	$325.50	$76.13	$764.90	$4,083.47
$5,500.00	$341.00	$79.75	$827.40	$4,251.85
$5,750.00	$356.50	$83.38	$889.90	$4,420.22
$6,000.00	$372.00	$87.00	$952.40	$4,588.60
$6,250.00	$387.50	$90.63	$1,014.90	$4,756.97
$6,500.00	$403.00	$94.25	$1,077.40	$4,925.35
$6,750.00	$418.50	$97.88	$1,139.90	$5,093.72
$7,000.00	$434.00	$101.50	$1,202.40	$5,262.10
$7,500.00	$465.00	$108.75	$1,327.40	$5,598.85
$8,000.00	$496.00	$116.00	$1,452.40	$5,935.60
$8,500.00	$527.00	$123.25	$1,587.77	$6,261.98
$9,000.00	$558.00	$130.50	$1,727.77	$6,583.73
$9,500.00	$587.45*****	$137.75	$1,867.77	$6,907.03
$10,000.00	$587.45	$145.00	$2,007.77	$7,259.78
$10,340.50******	$587.45	$149.94	$2,103.11	$7,500.00
$10,500.00	$587.45	$152.25	$2,147.77	$7,612.53
$11,000.00	$587.45	$159.50	$2,287.77	$7,965.28
$11,500.00	$587.45	$166.75	$2,427.77	$8,318.03
$12,000.00	$587.45	$174.00	$2,567.77	$8,670.78
$12,500.00	$587.45	$181.25	$2,707.77	$9,023.53
$13,000.00	$587.45	$188.50	$2,847.77	$9,376.28
$13,500.00	$587.45	$195.75	$2,987.77	$9,729.03
$14,000.00	$587.45	$203.00	$3,127.77	$10,081.78
$14,500.00	$587.45	$210.25	$3,267.77	$10,434.53
$15,000.00	$587.45	$217.50	$3,407.77	$10,787.28

Footnotes to Employed Persons 2013 Tax Chart:

* An employed person not subject to the Old-Age, Survivors and Disability Insurance/Hospital (Medicare) Insurance taxes will be allowed the reductions reflected in these columns, unless it is shown that such person has no similar contributory plan such as teacher retirement, federal railroad retirement, federal civil service retirement, etc.

** When income exceeds $200,000.00 per year there is an additional Medicare Tax of 0.9%. The additional Medicare Tax does not apply to any values shown on this chart because the highest gross income included is $15,000.00 per month ($180,000.00 per year).

*** These amounts represent one-twelfth (1/12) of the annual federal income tax calculated for a single taxpayer claiming one personal exemption ($3,900.00, subject to reduction in certain cases, as described below in this footnote) and taking the standard deduction ($6,100.00).

For a single taxpayer with an adjusted gross income in excess of $250,000.00, the deduction for the personal exemption is reduced by two percent (2%) for each $2,500.00 or fraction thereof by which adjusted gross income exceeds $250,000.00. The reduction is completed (i.e., the deduction for the personal exemption is eliminated) for adjusted gross income in excess of 372,500.00. In no case is the deduction for the personal exemption reduced by more than 100%. The phase out of the Personal Exemption does not apply to any values shown on this chart because the highest income included is $15,000.00 per month ($180,000.00 per year).

**** The amount represents one-twelfth (1/12) of the gross income of an individual earning the federal minimum wage ($7.25 per hour) for a 40-hour week for a full year. $7.25 per hour x 40 hours per week x 52 weeks per year equals $15,080.00 per year. One-twelfth (1/12) of $15,080.00 equals $1,256.67.

***** For annual gross wages above $113,700.00, this amount represents a monthly average of the Old-Age, Survivors and Disability Insurance tax based on the 2013 maximum Old-Age, Survivors and Disability Insurance tax of $7,049.40 per person (6.2% of the first $113,700.00 of annual gross wages equals $7,049.40). One-twelfth (1/12) of $7,049.40 equals $587.45.

****** This amount represents the point where the monthly gross wages of an employed individual would result in $7,500.00 of net resources. Texas Family Code section 154.125 provides "The guidelines for the support of a child in this section are specifically designed to apply to situations in which the obligor's monthly net resources are not greater than $7,500 or the adjusted amount determined under Subsection (a-1), whichever is greater." On September 1, 2013 this amount will be adjusted as required by Texas Family Code section 154.125. Before September 1, 2013 the Office of the Attorney General shall publish the adjusted amount in the Texas Register.

* *

References Relating to Employed Persons 2013 **Tax Chart:**

1. Old-Age, Survivors and Disability Insurance Tax

   (a) Contribution Base

(1) Social Security Administration's notice dated October 23, 2012 appearing in 77 Fed. Reg. 65754 (October 30, 2012)

(2) Section 3121(a) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 3121(a))

(3) Section 230 of the Social Security Act, as amended (42 U.S.C. § 430)

(b). Tax Rate

(1) Section 3101(a) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 3101(a))

2. Hospital (Medicare) Insurance Tax

(a) Contribution Base

(1) Section 3121(a) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 3121(a))

(2) Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13207, 107 Stat. 312, 467-69 (1993)

(b) Tax Rate

(1) Section 3101(b) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 3101(b))

3. Federal Income Tax

(a) Tax Rate Schedule for 2013 for Single Taxpayers

(1) Revenue Procedure 2013-15, Section 2.01, Table 3 which appears in Internal Revenue Bulletin 2013-5, dated January 28, 2013

(2) Section 1(c), (f) and (i) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 1(c), 1(f), 1(i))

(b) Standard Deduction

(1) Revenue Procedure 2013-15, Section 2.07(1), which appears in Internal Revenue Bulletin 2013-5, dated January 28, 2013

(2) Section 63(c) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 63(c))

(c) Personal Exemption

(1) Revenue Procedure 2013-15, Section 2.11, which appears in Internal Revenue Bulletin 2013-5, dated January 28, 2013

(2) Section 151(d) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 151(d))

SELF-EMPLOYED PERSONS
2013 TAX CHART

Monthly Net Earnings From Self-Employment*	Social Security Taxes: Old-Age, Survivors and Disability Insurance Taxes (12.4%)**	Social Security Taxes: Hospital (Medicare) Insurance Taxes (2.9%)**, ***	Federal Income Taxes****	Net Monthly Income
$100.00	$11.45	$2.68	$0.00	$85.87
$200.00	$22.90	$5.36	$0.00	$171.74
$300.00	$34.35	$8.03	$0.00	$257.62
$400.00	$45.81	$10.71	$0.00	$343.48
$500.00	$57.26	$13.39	$0.00	$429.35
$600.00	$68.71	$16.07	$0.00	$515.22
$700.00	$80.16	$18.75	$0.00	$601.09
$800.00	$91.61	$21.43	$0.00	$686.96
$900.00	$103.06	$24.10	$0.31	$772.53
$1,000.00	$114.51	$26.78	$9.60	$849.11
$1,100.00	$125.97	$29.46	$18.90	$925.67
$1,200.00	$137.42	$32.14	$28.19	$1,002.25
$1,300.00	$148.87	$34.82	$37.48	$1,078.83
$1,400.00	$160.32	$37.49	$46.78	$1,155.41
$1,500.00	$171.77	$40.17	$56.07	$1,231.99
$1,600.00	$183.22	$42.85	$65.36	$1,308.57
$1,700.00	$194.67	$45.53	$74.80	$1,385.00
$1,800.00	$206.13	$48.21	$88.74	$1,456.92
$1,900.00	$217.58	$50.88	$102.68	$1,528.86
$2,000.00	$229.03	$53.56	$116.62	$1,600.79
$2,100.00	$240.48	$56.24	$130.56	$1,672.72
$2,200.00	$251.93	$58.92	$144.50	$1,744.65
$2,300.00	$263.38	$61.60	$158.44	$1,816.58
$2,400.00	$274.83	$64.28	$172.38	$1,888.51
$2,500.00	$286.29	$66.95	$186.32	$1,960.44
$2,600.00	$297.74	$69.63	$200.26	$2,032.37
$2,700.00	$309.19	$72.31	$214.20	$2,104.30
$2,800.00	$320.64	$74.99	$228.14	$2,176.23
$2,900.00	$332.09	$77.67	$242.08	$2,248.16
$3,000.00	$343.54	$80.34	$256.02	$2,320.10
$3,100.00	$354.99	$83.02	$269.96	$2,392.03
$3,200.00	$366.44	$85.70	$283.90	$2,463.96
$3,300.00	$377.90	$88.38	$297.84	$2,535.88
$3,400.00	$389.35	$91.06	$311.78	$2,607.81
$3,500.00	$400.80	$93.74	$325.72	$2,679.74
$3,600.00	$412.25	$96.41	$339.66	$2,751.68
$3,700.00	$423.70	$99.09	$353.60	$2,823.61
$3,800.00	$435.15	$101.77	$367.54	$2,895.54
$3,900.00	$446.60	$104.45	$381.48	$2,967.47
$4,000.00	$458.06	$107.13	$395.42	$3,039.39
$4,250.00	$486.68	$113.82	$439.83	$3,209.67
$4,500.00	$515.31	$120.52	$497.92	$3,366.25
$4,750.00	$543.94	$127.21	$556.00	$3,522.85
$5,000.00	$572.57	$133.91	$614.09	$3,679.43
$5,250.00	$601.20	$140.60	$672.17	$3,836.03
$5,500.00	$629.83	$147.30	$730.25	$3,992.62
$5,750.00	$658.46	$153.99	$788.34	$4,149.21
$6,000.00	$687.08	$160.69	$846.42	$4,305.81
$6,250.00	$715.71	$167.38	$904.51	$4,462.40
$6,500.00	$744.34	$174.08	$962.59	$4,618.99
$6,750.00	$772.97	$180.78	$1,020.68	$4,775.57
$7,000.00	$801.60	$187.47	$1,078.76	$4,932.17
$7,500.00	$858.86	$200.86	$1,194.93	$5,245.35
$8,000.00	$916.11	$214.25	$1,311.10	$5,558.54
$8,500.00	$973.37	$227.64	$1,427.27	$5,871.72
$9,000.00	$1,030.63	$241.03	$1,549.74	$6,178.60
$9,500.00	$1,087.88	$254.42	$1,679.85	$6,477.85
$10,000.00	$1,145.14	$267.82	$1,809.96	$6,777.08
$10,500.00	$1,174.90*****	$281.21	$1,943.92	$7,099.97
$11,000.00	$1,174.90	$294.60	$2,082.04	$7,448.46
$11,073.95******	$1,174.90	$296.58	$2,102.47	$7,500.00
$11,500.00	$1,174.90	$307.99	$2,220.17	$7,796.94
$12,000.00	$1,174.90	$321.38	$2,358.29	$8,145.43
$12,500.00	$1,174.90	$334.77	$2,496.42	$8,493.91
$13,000.00	$1,174.90	$348.16	$2,634.54	$8,842.40
$13,500.00	$1,174.90	$361.55	$2,772.67	$9,190.88
$14,000.00	$1,174.90	$374.94	$2,910.79	$9,539.37
$14,500.00	$1,174.90	$388.33	$3,048.92	$9,887.85
$15,000.00	$1,174.90	$401.72	$3,187.04	$10,236.34

Footnotes to Self-Employed Persons 2013 Tax Chart:

* Determined without regard to Section 1402(a)(12) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 1402(a)(12)) (the "Code").

** In calculating each of the Old-Age, Survivors and Disability Insurance tax and the Hospital (Medicare) Insurance tax, net earnings from self-employment are reduced by the deduction under Section 1402(a)(12) of the Code. The deduction under Section 1402(a)(12) of the Code is equal to net earnings from self-employment (determined without regard to Section 1402(a)(12) of the Code) multiplied by one-half (1/2) of the sum of the Old-Age, Survivors and Disability Insurance tax rate (12.4%) and the Hospital (Medicare) Insurance tax rate (2.9%). The sum of these rates is 15.3% (12.4% + 2.9% = 15.3%). One-half (1/2) of the combined rate is 7.65% (15.3% x 1/2 = 7.65%). The deduction can be computed by multiplying the net earnings from self-employment (determined without regard to Section 1402(a)(12) of the Code) by 92.35%. This gives the same deduction as multiplying the net earnings from self-employment (determined without regard to Section 1402(a)(12) of the Code) by 7.65% and then subtracting the result.

For example, the Social Security taxes imposed on monthly net earnings from self-employment (determined without regard to Section 1402(a)(12) of the Code) of $2,500.00 are calculated as follows:

(i) Old-Age, Survivors and Disability Insurance Taxes:

$2,500.00 x 92.35% x 12.4% = $286.29

(ii) Hospital (Medicare) Insurance Taxes:

$2,500.00 x 92.35% x 2.9% = $66.95

*** When income exceeds $200,000.00 per year there is an additional Medicare Tax of 0.9%. The additional Medicare Tax does not apply to any values shown on this chart because the highest gross income included is $15,000.00 per month ($180,000.00 per year).

**** These amounts represent one-twelfth (1/12) of the annual federal income tax calculated for a single taxpayer claiming one personal exemption ($3,900.00, subject to reduction in certain cases, as described below in this footnote) and taking the standard deduction ($6,100.00).

In calculating the annual federal income tax, gross income is reduced by the deduction under Section 164(f) of the Code. For example, monthly net earnings from self-employment of $8,500.00 times 12 months equals $102,000.00. The Old-Age, Survivors and Disability Insurance taxes imposed by Section 1401 of the Code for the taxable year equal $9,796.49 ($102,000.00 x .9235 x 12.4% = $11,680.43). The Hospital (Medicare) Insurance taxes imposed by Section 1401 of the Code for the taxable year equal $2,731.71 ($102,000.00 x .9235 x 2.9% = $2,731.71). The deduction under Section 164(f) of the Code for 2013 is equal to $7,206.08 (($11,680.43 x 0.5) + ($2,731.72 x 0.5) = $7,206.08).

For a single taxpayer with an adjusted gross income in excess of $250,000.00, the deduction for the personal exemption is reduced by two percent (2%) for each $2,500.00 or fraction thereof by which adjusted gross income exceeds $250,000.00. The reduction is completed (i.e., the deduction for the personal exemption is eliminated) for adjusted

gross income in excess of $372,500.00. In no case is the deduction for the personal exemption reduced by more than 100%. The phase out of the Personal Exemption does not apply to any values shown on this chart because the highest income included is $15,000.00 per month ($180,000.00 per year).

***** For annual net earnings from self-employment (determined with regard to Section 1402(a)(12) of the Code) above $113,700.00, this amount represents a monthly average of the Old-Age, Survivors and Disability Insurance tax based on the 2013 maximum Old-Age, Survivors and Disability Insurance tax of $14,098.80 per person (12.4% of the first $113,700.00 of net earnings from self-employment (determined with regard to Section 1402(a)(12) of the Code) equals $14,098.80). One-twelfth (1/12) of $14,098.80 equals $1,174.90.

****** This amount represents the point where the monthly net earnings from self-employment of a self-employed individual would result in $7,500.00 of net resources. Texas Family Code section 154.125 provides "The guidelines for the support of a child in this section are specifically designed to apply to situations in which the obligor's monthly net resources are not greater than $7,500 or the adjusted amount determined under Subsection (a-1), whichever is greater." On September 1, 2013 this amount will be adjusted as required by Texas Family Code section 154.125. Before September 1, 2013 the Office of the Attorney General shall publish the adjusted amount in the Texas Register.

* *

References Relating to Self-Employed Persons 2013 Tax Chart:

1. Old-Age, Survivors and Disability Insurance Tax

   (a) Contribution Base

      (1) Social Security Administration's notice dated October 23, 2012 appearing in 77 Fed. Reg. 65754 (October 30, 2012)

      (2) Section 1402(b) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 1402(b))

      (3) Section 230 of the Social Security Act, as amended (42 U.S.C. § 430)

   (b) Tax Rate

      (1) Section 1401(a) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 1401(a))

   (c) Deduction Under Section 1402(a)(12)

      (1) Section 1402(a)(12) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 1402(a)(12))

2. Hospital (Medicare) Insurance Tax

   (a) Contribution Base

(1) Section 1402(b) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 1402(b))

(2) Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13207, 107 Stat. 312, 467-69 (1993)

(b) Tax Rate

(1) (1) Section 1401(b) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 1401(b))

(c) Deduction Under Section 1402(a)(12)

(1) Section 1402(a)(12) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 1402(a)(12))

3. Federal Income Tax

(a) Tax Rate Schedule for 2013 for Single Taxpayers

(1) Revenue Procedure 2013-15, Section 2.01, Table 3 which appears in Internal Revenue Bulletin 2013-5, dated January 28, 2013

(2) Section 1(c), (f) and (i) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 1(c), 1(f), 1(i))

(b) Standard Deduction

(1) Revenue Procedure 2013-15, Section 2.07(1), which appears in Internal Revenue Bulletin 2013-5, dated January 28, 2013

(1) Section 63(c) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 63(c))

(c) Personal Exemption

(1) Revenue Procedure 2013-15, Section 2.11, which appears in Internal Revenue Bulletin 2013-5, dated January 28, 2013

(2) Section 151(d) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 151(d))

(d) Deduction Under Section 164(f)

(1) Section 164(f) of the Internal Revenue Code of 1986, as amended (26 U.S.C. § 164(f))

TRD-201300447
Katherine Cary
General Counsel
Office of the Attorney General
Filed: February 4, 2013

♦ ♦ ♦

Texas Health and Safety Code and Texas Water Code Settlement Notice

Notice is hereby given by the State of Texas of the following proposed resolution of an environmental enforcement lawsuit under the Texas Health and Safety Code and the Texas Water Code. Before the State may settle a judicial enforcement action under the Water Code, the State shall permit the public to comment in writing on the proposed judgment. The Attorney General will consider any written comments and may withdraw or withhold consent to the proposed agreed judgment if the comments disclose facts or considerations that indicate that the consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the Code.

Case Title and Court: *Harris County, Texas and the State of Texas acting on behalf of the Texas Commission on Environmental Quality, A Necessary and Indispensable Party v. Airgas Specialty Gases, Inc.,* Cause No. 2012-66790, in the 55th Judicial District Court of Harris County, Texas.

Nature of Defendant's Operations: Defendant Airgas Specialty Gases, Inc. ("Airgas") operates a facility in Houston, Texas which stores, transports, and manages compressed petroleum gases. Defendant violated the Texas Water Code and Texas Clean Air Act by venting ethylene gas into the atmosphere.

Proposed Agreed Judgment: The proposed Agreed Final Judgment is in favor of Harris County, Texas and the State in the amount of Thirty-Five Thousand Dollars ($35,000.00) in civil penalties to be equally divided between Harris County and the State of Texas. Defendant is also required to pay attorney fees in the amount of One Thousand Five Hundred Dollars ($1,500.00) to the State of Texas.

For a complete description of the proposed settlement, the complete proposed Agreed Final Judgment should be reviewed. Requests for copies of the judgment and written comments on the proposed settlement should be directed to Anthony W. Benedict, Assistant Attorney General, Office of the Texas Attorney General, P.O. Box 12548, Austin, Texas 78711-2548, (512) 463-2012, facsimile (512) 320-0911. Written comments must be received within 30 days of publication of this notice to be considered.

TRD-201300453
Katherine Cary
General Counsel
Office of the Attorney General
Filed: February 5, 2013

♦ ♦ ♦

Comptroller of Public Accounts

Notice of Request for Applications

Pursuant to Chapters 403, 447 and 2305, Texas Government Code; and the State Energy Plan (SEP) and related legal authority and regulations, the Texas Comptroller of Public Accounts (Comptroller), State Energy Conservation Office, announces this Request for Applications (RFA #IED-G1-2013) and Notice of Funding Availability of $2,000,000.00 (individual awards, if any, are not-to-exceed $250,000.00) in grant funding and invites applications from eligible interested publically funded entities for grant funds for the Innovative Energy Demonstration Program of the State Energy Conservation Office. To be eligible, prospective applicants must be a Texas city, county, independent school district, state agency or public institution of higher education, and applications must include a twenty percent (20%) match of total project costs. Comptroller reserves the right to award more than one grant under the terms of this RFA. If a grant award is made under the terms of the RFA, selected applicants will be expected to begin performance of the grant agreement on or about April 1, 2013, or as soon thereafter as practical.

Contact: For general questions about these instructions or the application form, please contact Jason C. Frizzell, Assistant General Counsel, Contracts, Texas Comptroller of Public Accounts, at: 111 E. 17th Street, Room 201, Austin, Texas 78774 (Issuing Office) via email to contracts@cpa.state.tx.us or fax to (512) 463-3669. This RFA will be published after 10:00 a.m. Central Time (CT) on Friday, February 15, 2013 and posted on the Electronic State Business Daily (ESBD) at: http://esbd.cpa.state.tx.us after 10:00 a.m. CT on Friday, February 15, 2013. The application and sample grant agreement will be posted on the following website shortly thereafter: http://www.seco.cpa.state.tx.us/funding/.

Questions: All written inquiries and questions must be received in the Issuing Office no later than 2:00 p.m. CT on February 22, 2013. Prospective applicants are encouraged to send questions via email to contracts@cpa.states.tx.us or fax to (512) 463-3669 to ensure timely receipt. On or about March 1, 2013, or as soon thereafter as practical, Comptroller expects to post responses to the questions received by the deadline on the ESBD website at: http://esbd.cpa.state.tx.us/. Late Questions will not be considered under any circumstances.

Closing Date: Applications must be delivered to the Issuing Office to the attention of the Assistant General Counsel, Contracts, no later than 2:00 p.m. CT, on Friday, March 15, 2013. Comptroller will NOT accept applications submitted via fax or email. Late applications will not be accepted or considered under any circumstances.

Evaluation Criteria: Applications will be evaluated under the criteria outlined in the grant application and instructions for this RFA. Comptroller reserves the right to accept or reject any or all applications submitted. Comptroller is not obligated to execute a grant agreement on the basis of this notice or the distribution of any RFA. Comptroller shall not pay for any costs incurred by any entity in responding to this Notice or to the RFA.

The anticipated schedule of events pertaining to this RFA is as follows: Issuance of RFA - February 15, 2013, after 10:00 a.m. CT; Questions Due - February 22, 2013, 2:00 p.m. CT; Official Responses to Questions posted - March 1, 2013; Applications Due - March 15, 2013, 2:00 p.m. CT; Grant Agreement Execution - March 31, 2013, or as soon thereafter as practical; Commencement of Project - April 1, 2013, or as soon thereafter as practical.

TRD-201300471
Jason C. Frizzell
Assistant General Counsel, Contracts
Comptroller of Public Accounts
Filed: February 6, 2013

♦ ♦ ♦

Office of Consumer Credit Commissioner

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in §§303.003, 303.005, and 303.009, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 02/11/13 - 02/17/13 is 18% for Consumer[1]/Agricultural/Commercial[2] credit through $250,000.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 02/11/13 - 02/17/13 is 18% for Commercial over $250,000.

The monthly ceiling as prescribed by §303.005[3] for the period of 02/01/13 - 02/28/13 is 18% for Consumer/Agricultural/Commercial/credit through $250,000.

The monthly ceiling as prescribed by §303.005 for the period of 02/01/13 - 02/28/13 is 18% for Commercial over $250,000.

[1] Credit for personal, family or household use.

[2] Credit for business, commercial, investment or other similar purpose.

[3] For variable rate commercial transactions only.

TRD-201300466
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: February 5, 2013

♦ ♦ ♦

Texas Commission on Environmental Quality

Agreed Orders

The Texas Commission on Environmental Quality (TCEQ, agency or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (TWC), §7.075. TWC, §7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. TWC, §7.075 requires that notice of the proposed orders and the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is March 18, 2013. TWC, §7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building C, 1st Floor, Austin, Texas 78753, (512) 239-2545 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the enforcement coordinator designated for each AO at the commission's central office at P.O. Box 13087, Austin, Texas 78711-3087 and must be received by 5:00 p.m. on March 18, 2013. Written comments may also be sent by facsimile machine to the enforcement coordinator at (512) 239-2550. The commission enforcement coordinators are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, TWC, §7.075 provides that comments on the AOs shall be submitted to the commission in **writing.**

(1) COMPANY: Afshan & Iftikhar Enterprises, Incorporated dba Rite Track 15; DOCKET NUMBER: 2012-1695-PST-E; IDENTIFIER: RN102348737; LOCATION: Daingerfield, Morris County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.49(a) and TWC, §26.3475(d), by failing to provide corrosion protection for the underground storage tank (UST) system; 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the USTs for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); and 30 TAC §334.10(b), by failing to maintain UST records and making them immediately available for inspection upon request by agency personnel; PENALTY: $8,750; ENFORCEMENT COORDINATOR: Had Darling, (512) 239-2570; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(2) COMPANY: Air Liquide Large Industries U.S. LP; DOCKET NUMBER: 2012-1992-AIR-E; IDENTIFIER: RN100233998; LOCATION: Pasadena, Harris County; TYPE OF FACILITY: cogeneration and air separation plant; RULE VIOLATED: 30 TAC §116.615(2) and §122.143(4), Federal Operating Permit Number O-1735, Special Terms and Conditions Number 5, Air Quality Standard Permit for Electric Generating Units Registration Number 75225, and Texas Health and Safety Code, §382.085(b), by failing to maintain compliance with the nitrogen oxides hourly maximum allowable emissions rate for Combustion Gas Turbine/Heat Recovery Steam Generator Set Numbers 1, 2, and 4; PENALTY: $10,800; Supplemental Environmental Project offset amount of $4,320 applied to Houston - Galveston Area Emission Reduction Credit Organization's Clean Cities/Clean Vehicles Program; ENFORCEMENT COORDINATOR: Heather Podlipny, (512) 239-2603; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(3) COMPANY: Big Tex Transportation, Incorporated dba Big Tex Fuel Stop; DOCKET NUMBER: 2012-2412-PST-E; IDENTIFIER: RN101444495; LOCATION: Mount Pleasant, Titus County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and (2) and TWC, §26.3475(a) and (c)(1), by failing to monitor the underground storage tanks (USTs) for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring) and by failing to provide proper release detection for the pressurized piping associated with the UST system; PENALTY: $3,504; ENFORCEMENT COORDINATOR: David Carney, (512) 239-2583; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(4) COMPANY: Billy Del Goodman dba Goodman's; DOCKET NUMBER: 2012-2034-PST-E; IDENTIFIER: RN102929049; LOCATION: Longview, Gregg County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.49(a)(1) and TWC, §26.3475(d), by failing to provide proper corrosion protection for the underground storage tank system; PENALTY: $3,375; ENFORCEMENT COORDINATOR: David Carney, (512) 239-2583; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(5) COMPANY: CHEVRON PHILLIPS CHEMICAL COMPANY LP; DOCKET NUMBER: 2012-1824-MLM-E; IDENTIFIER: RN102320850; LOCATION: Borger, Hutchinson County; TYPE OF FACILITY: produces specialty chemicals and engineering plastics; RULE VIOLATED: 30 TAC §335.69(a)(2) and 40 Code of Federal Regulations §262.34(a)(2), by failing to indicate the beginning date of accumulation on each container; and 30 TAC §331.7 and Underground Injection Control Permit Numbers WDW067 and WDW219, Part VI. Waste Streams Prohibited From Injection, by failing to prevent the unauthorized injection of a hazardous waste into a Class 1 non-hazardous injection well; PENALTY: $32,813; ENFORCEMENT COORDINATOR: Danielle Porras, (713) 767-3682; REGIONAL OFFICE: 3918 Canyon Drive, Amarillo, Texas 79109-4933, (806) 353-9251.

(6) COMPANY: CHUBBIES INVESTMENTS, INCORPORATED dba Super One Store; DOCKET NUMBER: 2013-0143-PST-E; IDENTIFIER: RN102275955; LOCATION: Liberty, Liberty County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.49(a)(1) and TWC, §26.3475(d), by failing to provide corrosion protection for the underground storage tank system; PENALTY: $2,625; ENFORCEMENT COORDINATOR: Rebecca Boyett, (512) 239-2503; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(7) COMPANY: City of Bullard; DOCKET NUMBER: 2012-1062-MWD-E; IDENTIFIER: RN101720639; LOCATION: Bullard, Cherokee County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: TWC, §26.121(a)(1), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System Permit Number WQ0011787001, Interim Effluent Limitations and Monitoring Requirements Numbers 1 and 6, by failing to comply with permitted effluent limitations; PENALTY: $15,600; Supplemental Environmental Project offset amount of $12,480 applied to Lynch Street Sewer Rehabilitation Project; ENFORCEMENT COORDINATOR: Jacquelyn Green, (512) 239-2587; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(8) COMPANY: City of Deer Park; DOCKET NUMBER: 2012-1952-PST-E; IDENTIFIER: RN106000565; LOCATION: Deer Park, Harris County; TYPE OF FACILITY: fleet refueling service; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and (2) and TWC, §26.3475(a) and (c)(1), by failing to monitor the underground storage tank (UST) system for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring) and by failing to provide proper release detection for the product piping associated with the UST system; PENALTY: $3,750; ENFORCEMENT COORDINATOR: Had Darling, (512) 239-2570; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(9) COMPANY: COOPER NATURAL RESOURCES, INCORPORATED; DOCKET NUMBER: 2012-1719-IHW-E; IDENTIFIER: RN105587018; LOCATION: Seagraves, Gaines County; TYPE OF FACILITY: chemical distribution; RULE VIOLATED: 30 TAC §335.4(1), by failing to prevent the unauthorized discharge of industrial solid waste; PENALTY: $2,140; ENFORCEMENT COORDINATOR: Clinton Sims, (512) 239-6933; REGIONAL OFFICE: 9900 West IH-20, Suite 100, Midland, Texas 79706, (432) 570-1359.

(10) COMPANY: DALLAS CTG CORPORATION dba North Oak Grocery; DOCKET NUMBER: 2012-2000-PST-E; IDENTIFIER: RN102016599; LOCATION: White Oak, Gregg County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the underground storage tank for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $3,375; ENFORCEMENT COORDINATOR: Had Darling, (512) 239-2570; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(11) COMPANY: Donny Burnett dba East Texas Crushed Rock; DOCKET NUMBER: 2012-1840-AIR-E; IDENTIFIER: RN106421282; LOCATION: Larue, Henderson County; TYPE OF FACILITY: portable rock crusher; RULE VIOLATED: 30 TAC §116.110(a) and Texas Health and Safety Code, §382.0518(a) and §382.085(b), by failing to obtain authorization to construct and operate a rock crusher; PENALTY: $10,000; ENFORCEMENT COORDINATOR: Heather Podlipny, (512) 239-2603; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(12) COMPANY: EAGLE's DROP LLC; DOCKET NUMBER: 2012-0970-MLM-E; IDENTIFIER: RN106299738; LOCATION: Willis, Montgomery County; TYPE OF FACILITY: commercial property; RULE VIOLATED: 30 TAC §101.4 and §111.201, and Texas Health and Safety Code, §382.085(a) and (b), by failing to comply with the general prohibition on outdoor burning; and 30 TAC §330.15(c), by failing to prevent the unauthorized disposal of municipal solid waste at the site; PENALTY: $2,016; ENFORCEMENT COORDINATOR: Audra Benoit, (409) 899-8799; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(13) COMPANY: Equistar Chemicals, LP; DOCKET NUMBER: 2012-2074-AIR-E; IDENTIFIER: RN100542281; LOCATION: Channelview, Harris County; TYPE OF FACILITY: chemical manufacturing plant; RULE VIOLATED: 30 TAC §116.115(c), Texas Health and Safety Code, §382.082(b), and New Source Review Permit Number 2128, Special Conditions Number 1, by failing to prevent unauthorized emissions during an emissions event that occurred on May 20, 2012; PENALTY: $14,250; Supplemental Environmental Project offset amount of $5,700 applied to Barbers Hill Independent School District - Alternative Fueled Vehicle and Equipment Program; ENFORCEMENT COORDINATOR: Heather Podlipny, (512) 239-2603; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(14) COMPANY: Grover Boyd dba Road Runner Superette 2; DOCKET NUMBER: 2012-2118-PST-E; IDENTIFIER: RN101838910; LOCATION: Longview, Gregg County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and (2) and TWC, §26.3475(a) and (c)(1), by failing to monitor the underground storage tank (UST) system for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring) and by failing to provide proper release detection for the product piping associated with the UST system; PENALTY: $3,886; ENFORCEMENT COORDINATOR: Had Darling, (512) 239-2570; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(15) COMPANY: Ha Van Nguyen dba Austin Aqua System; DOCKET NUMBER: 2012-1620-PWS-E; IDENTIFIER: RN101197986; LOCATION: Burnet, Burnet County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.106(e), by failing to report the results of annual nitrate monitoring to the executive director; 30 TAC §§290.106(e), 290.108(e), and 290.113(e), by failing to report the results of triennial mineral, metal, radionuclide, and Stage 1 Disinfectant Byproduct monitoring to the executive director; and 30 TAC §290.110(e)(4) and (f)(3), by failing to submit a Disinfectant Quarterly Level Report to the executive director each quarter by the tenth day of the month following the end of each quarter; PENALTY: $1,610; ENFORCEMENT COORDINATOR: Jim Fisher, (512) 239-2537; REGIONAL OFFICE: 12100 Park 35 Circle, Austin, Texas 78753, (512) 339-2929.

(16) COMPANY: Jai L N, Incorporated dba Nomads; DOCKET NUMBER: 2013-0142-PST-E; IDENTIFIER: RN102391455; LOCATION: Belton, Bell County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the underground storage tanks for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $2,625; ENFORCEMENT COORDINATOR: Rebecca Boyett, (512) 239-2503; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(17) COMPANY: Kuraray America, Incorporated; DOCKET NUMBER: 2012-1780-AIR-E; IDENTIFIER: RN100212216; LOCATION: Pasadena, Harris County; TYPE OF FACILITY: chemical manufac-

turing plant; RULE VIOLATED: 30 TAC §§115.352(4), 116.115(c) and 122.143(4), 40 Code of Federal Regulations §60.482-6(a)(1) and §63.167(a)(1), Texas Health and Safety Code, §382.085(b), Federal Operating Permit Number O1561, Special Terms and Conditions Numbers 1A and 13, and New Source Review Permit Number 9576, Special Conditions Number 15E, by failing to maintain a cap, blind flange, plug, or second valve on open-ended lines or valves; PENALTY: $4,565; ENFORCEMENT COORDINATOR: Audra Benoit, (409) 899-8799; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(18) COMPANY: LEIBOLD - GROTHUES RANCH, LTD. dba Lake Medina RV Resort; DOCKET NUMBER: 2012-2039-PWS-E; IDENTIFIER: RN101252880; LOCATION: Pipe Creek, Bandera County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.109(c)(2)(F) and §290.122(f), by failing to collect at least five routine distribution coliform samples the month following a coliform-positive sample result, and by failing to timely submit to the executive director a copy of a public notice of the failure to collect increased coliform sampling during the month it was required; 30 TAC §290.109(c)(3)(A)(i), by failing to collect a set of repeat distribution coliform samples within 24 hours of being notified of a total coliform-positive result on a routine sample; and 30 TAC §290.109(f)(3) and Texas Health and Safety Code, §341.031(a), by failing to comply with the Maximum Contaminant Level for total coliform; PENALTY: $2,223; ENFORCEMENT COORDINATOR: Jim Fisher, (512) 239-2537; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(19) COMPANY: Lhoist North America of Texas, Ltd.; DOCKET NUMBER: 2012-1862-AIR-E; IDENTIFIER: RN100552454; LOCATION: New Braunfels, Comal County; TYPE OF FACILITY: lime manufacturing plant; RULE VIOLATED: 30 TAC §§116.115(b)(2)(F) and (c), 122.143(4) and 101.20(3), New Source Review (NSR) Permit Numbers 7808 and PSDTX256M3, Special Conditions (SC) Number 1, Federal Operating Permit (FOP) Number O-01122, Special Terms and Conditions (STC) Number 8, and Texas Health and Safety Code (THSC), §382.085(b), by failing to maintain an emissions rate below the allowable emissions rate; and 30 TAC §§116.115(b)(2)(F) and (c), 122.143(4) and 101.20(3), NSR Permit Numbers 7808 and PSDTX256M3, SC Number 3, FOP Number O-01122, STC Number 8, and THSC, §382.085(b), by failing to maintain an emissions limit below the allowable emissions limit; PENALTY: $15,075; ENFORCEMENT COORDINATOR: Heather Podlipny, (512) 239-2603; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(20) COMPANY: MAT-J, L.L.C. dba Lone Star Number 7; DOCKET NUMBER: 2012-1998-PST-E; IDENTIFIER: RN101805984; LOCATION: Longview, Gregg County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(2) and TWC, §26.3475(a), by failing to provide release detection for the product piping associated with the underground storage tank system; PENALTY: $2,571; ENFORCEMENT COORDINATOR: Had Darling, (512) 239-2570; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(21) COMPANY: Mesneak, William K.; DOCKET NUMBER: 2013-0179-WOC-E; IDENTIFIER: RN106266646; LOCATION: Skellytown, Carson County; TYPE OF FACILITY: individual; RULE VIOLATED: 30 TAC §30.5(a), by failing to obtain a required occupational license; PENALTY: $175; ENFORCEMENT COORDINATOR: Heather Podlipny, (512) 239-2603; REGIONAL OFFICE: 3918 Canyon Drive, Amarillo, Texas 79109-4933, (806) 353-9251.

(22) COMPANY: MUGHAL, INCORPORATED dba Wilson Food Mart 2; DOCKET NUMBER: 2012-2145-PST-E; IDENTIFIER: RN101776219; LOCATION: Humble, Harris County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the underground storage tanks for releases at a frequency of at least once per month (not to exceed 35 days between each monitoring); PENALTY: $2,813; ENFORCEMENT COORDINATOR: Danielle Porras, (713) 767-3682; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(23) COMPANY: Myeong Jeong dba C & S Store; DOCKET NUMBER: 2012-2313-PST-E; IDENTIFIER: RN101440055; LOCATION: Cypress, Harris County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(2) and TWC, §26.3475(a), by failing to provide release detection for the pressurized piping associated with the underground storage tank system; PENALTY: $5,004; ENFORCEMENT COORDINATOR: Had Darling, (512) 239-2570; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(24) COMPANY: New Medical Horizons, II, Ltd.; DOCKET NUMBER: 2012-2600-PST-E; IDENTIFIER: RN100640192; LOCATION: Houston, Harris County; TYPE OF FACILITY: hospital; RULE VIOLATED: 30 TAC §334.50(b)(2) and TWC, §26.3475(b), by failing to provide release detection for the suction piping associated with the underground storage tank (UST) system; and 30 TAC §334.8(c)(5)(A)(i) and TWC, §26.3467(a), by failing to make available to a common carrier a valid, current TCEQ delivery certificate before accepting delivery of a regulated substance into the UST; PENALTY: $3,500; ENFORCEMENT COORDINATOR: Jessica Schildwachter, (512) 239-2617; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(25) COMPANY: Noble Business, Incorporated dba Z Mini Mart; DOCKET NUMBER: 2012-2149-PST-E; IDENTIFIER: RN102347192; LOCATION: Fort Worth, Tarrant County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the underground storage tanks for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $3,375; ENFORCEMENT COORDINATOR: David Carney, (512) 239-2583; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(26) COMPANY: Prapti, LLC dba Deer Park Grocery; DOCKET NUMBER: 2012-1888-PST-E; IDENTIFIER: RN101879203; LOCATION: Deer Park, Harris County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the underground storage tanks for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $2,888; ENFORCEMENT COORDINATOR: Had Darling, (512) 239-2570; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(27) COMPANY: SAW STORE, INCORPORATED DBA Jack's Super Mart; DOCKET NUMBER: 2012-2133-PST-E; IDENTIFIER: RN101436145; LOCATION: La Porte, Harris County; TYPE OF FACILITY: convenience store with retail gasoline sales; RULE VIOLATED: TWC, §26.3475(d) and 30 TAC §334.49(a)(1), by failing to provide corrosion protection for the underground storage tank system; PENALTY: $2,568; ENFORCEMENT COORDINATOR: Harvey Wilson, (512) 239-0321; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(28) COMPANY: SBN ENT, INCORPORATED dba Speedys; DOCKET NUMBER: 2013-0141-PST-E; IDENTIFIER:

RN102352911; LOCATION: Tyler, Smith County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the underground storage tanks for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $2,625; ENFORCEMENT COORDINATOR: Rebecca Boyett, (512) 239-2503; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(29) COMPANY: SHAHIL CORPORATION dba Springtime Food Store; DOCKET NUMBER: 2013-0115-PST-E; IDENTIFIER: RN101856136; LOCATION: Spring, Montgomery County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.49(a)(1) and TWC, §26.3475(d), by failing to provide corrosion protection for the underground storage tank system; PENALTY: $2,625; ENFORCEMENT COORDINATOR: Margarita Dennis, (512) 239-2579; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(30) COMPANY: Southern Star Concrete, Incorporated; DOCKET NUMBER: 2012-2243-AIR-E; IDENTIFIER: RN100249416; LOCATION: Houston, Harris County; TYPE OF FACILITY: concrete batch plant; RULE VIOLATED: 30 TAC §116.110(a) and Texas Health and Safety Code, §382.0518(a) and §382.085(b), by failing to renew authorization for New Source Review Permit Number 49066 prior to the permit expiration date of August 7, 2012; PENALTY: $3,750; ENFORCEMENT COORDINATOR: Heather Podlipny, (512) 239-2603; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(31) COMPANY: Tarkington - Safari Investments, Incorporated dba Tarkington Country Mart; DOCKET NUMBER: 2012-2207-PST-E; IDENTIFIER: RN101842490; LOCATION: Cleveland, Liberty County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the underground storage tanks for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $3,750; ENFORCEMENT COORDINATOR: Andrea Park, (713) 422-8970; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(32) COMPANY: Texas Department of Transportation; DOCKET NUMBER: 2012-1177-MWD-E; IDENTIFIER: RN106479983; LOCATION: Richland, Navarro County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: TWC, §26.121(a)(1), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System Permit Number WQ0014854001, Effluent Limitations and Monitoring Requirements Numbers 1 and 2, by failing to comply with permitted effluent limits; PENALTY: $13,500; Supplemental Environmental Project offset amount of $13,500 applied to Texas Association of Resource Conservation and Development Areas, Incorporated - Water or Wastewater Treatment Assistance; ENFORCEMENT COORDINATOR: Heather Brister, (254) 761-3034; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(33) COMPANY: Travis County Municipal Utility District Number 10; DOCKET NUMBER: 2012-1852-PWS-E; IDENTIFIER: RN101422533; LOCATION: Lago Vista, Travis County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.113(f)(4) and Texas Health and Safety Code, §341.0315(c), by failing to comply with the maximum contaminant level of 0.080 milligrams per liter for total trihalomethanes based on the running annual average; PENALTY: $183; ENFORCEMENT COORDINATOR: Heather Brister, (254) 761-3034; REGIONAL OFFICE: 12100 Park 35 Circle, Austin, Texas 78753, (512) 339-2929.

(34) COMPANY: Weatherford Independent School District; DOCKET NUMBER: 2012-2285-PST-E; IDENTIFIER: RN101885952; LOCATION: Weatherford, Parker County; TYPE OF FACILITY: fleet refueling; RULE VIOLATED: 30 TAC §334.49(a)(1) and TWC, §26.3475(d), by failing to provide corrosion protection for the underground storage tank (UST) system; 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the USTs for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); and 30 TAC §334.10(b)(1)(B), by failing to maintain UST records and making them immediately available for inspection upon request by agency personnel; PENALTY: $6,564; ENFORCEMENT COORDINATOR: Brianna Carlson, (965) 430-6021; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

TRD-201300451
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: February 5, 2013

♦ ♦ ♦

Enforcement Orders

An agreed order was entered regarding Hardeep Singh dba Paris Mart, Docket No. 2012-0128-PST-E on January 22, 2013 assessing $5,000 in administrative penalties with $1,000 deferred.

Information concerning any aspect of this order may be obtained by contacting Michael Meyer, Enforcement Coordinator at (512) 239-4492, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding WEST AVENUE EXPRESS, INC. dba Fuel Station # 3, Docket No. 2012-0228-PST-E on January 22, 2013 assessing $5,000 in administrative penalties with $1,000 deferred.

Information concerning any aspect of this order may be obtained by contacting Steve Villatoro, Enforcement Coordinator at (512) 239-4930, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Country Club Retirement Community, L.P., Docket No. 2012-0448-MWD-E on January 22, 2013 assessing $7,060 in administrative penalties with $1,412 deferred.

Information concerning any aspect of this order may be obtained by contacting Stephen Thompson, Enforcement Coordinator at (512) 239-2558, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Todd Helms dba Superior Auto Sales, Docket No. 2012-0620-MSW-E on January 22, 2013 assessing $262 in administrative penalties with $52 deferred.

Information concerning any aspect of this order may be obtained by contacting Michael Meyer, Enforcement Coordinator at (512) 239-4492, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding COUSIN BROTHERS CORPORATION dba Express Truck Stop, Docket No. 2012-0675-PST-E on January 22, 2013 assessing $2,801 in administrative penalties with $560 deferred.

Information concerning any aspect of this order may be obtained by contacting Thomas Greimel, Enforcement Coordinator at (512) 239-5690, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Batesville Water Supply Corporation, Docket No. 2012-0743-MWD-E on January 22, 2013 assessing $2,550 in administrative penalties with $510 deferred.

Information concerning any aspect of this order may be obtained by contacting Jeremy Escobar, Enforcement Coordinator at (361) 825-3422, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding SHAMU CORPORATION dba EZ for U Food Store, Docket No. 2012-0814-PST-E on January 22, 2013 assessing $5,082 in administrative penalties with $1,016 deferred.

Information concerning any aspect of this order may be obtained by contacting Maggie Dennis, Enforcement Coordinator at (512) 239-2578, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding PDK LIQUID STONE PARTNERS, L.P. dba Liquid-Stone Concrete, Docket No. 2012-0836-IWD-E on January 22, 2013 assessing $2,300 in administrative penalties with $460 deferred.

Information concerning any aspect of this order may be obtained by contacting Heather Brister, Enforcement Coordinator at (254) 761-3034, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Jai Kapish Corporation dba Stop and Shop 3, Docket No. 2012-0857-PST-E on January 22, 2013 assessing $3,131 in administrative penalties with $626 deferred.

Information concerning any aspect of this order may be obtained by contacting Heather Brister, Enforcement Coordinator at (254) 761-3034, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding American Concrete & Gunite, LP, Docket No. 2012-0890-IWD-E on January 22, 2013 assessing $2,450 in administrative penalties with $490 deferred.

Information concerning any aspect of this order may be obtained by contacting Heather Brister, Enforcement Coordinator at (254) 761-3034, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Tri-Community Water Supply Corporation, Docket No. 2012-0891-PWS-E on January 22, 2013 assessing $2,193 in administrative penalties with $438 deferred.

Information concerning any aspect of this order may be obtained by contacting Epifanio Villareal, Enforcement Coordinator at (361) 825-3425, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Bandera Shell LLC dba Bandera Shell Car Care, Docket No. 2012-0904-PST-E on January 22, 2013 assessing $5,000 in administrative penalties with $1,000 deferred.

Information concerning any aspect of this order may be obtained by contacting Michael Meyer, Enforcement Coordinator at (512) 239-4492, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Yedneckachew Worke dba Longview TD Mart, Docket No. 2012-0920-PST-E on January 22, 2013 assessing $3,629 in administrative penalties with $725 deferred.

Information concerning any aspect of this order may be obtained by contacting Judy Kluge, Enforcement Coordinator at (817) 588-5825, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding JIMMIE HAHN PARTNERSHIP, LTD., Docket No. 2012-1021-IWD-E on January 22, 2013 assessing $3,750 in administrative penalties with $750 deferred.

Information concerning any aspect of this order may be obtained by contacting Lanae Foard, Enforcement Coordinator at (512) 239-2554, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Thomas Carranza dba Trinity Crossing, Docket No. 2012-1041-PWS-E on January 22, 2013 assessing $1,185 in administrative penalties with $237 deferred.

Information concerning any aspect of this order may be obtained by contacting Epifanio Villareal, Enforcement Coordinator at (325) 825-3425, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding ASAA Investment Inc. dba In & Out Express 2, Docket No. 2012-1051-PST-E on January 22, 2013 assessing $1,625 in administrative penalties with $325 deferred.

Information concerning any aspect of this order may be obtained by contacting Jorge Ibarra, P.E., Enforcement Coordinator at (817) 588-5890, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding BURMHI & SONS INC dba Kilgore Food Mart, Docket No. 2012-1053-PST-E on January 22, 2013 assessing $2,500 in administrative penalties with $500 deferred.

Information concerning any aspect of this order may be obtained by contacting Andrea Park, Enforcement Coordinator at (713) 422-8970, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Dream Enterprises Inc. dba Gibby's Food Store, Docket No. 2012-1092-PST-E on January 22, 2013 assessing $3,050 in administrative penalties with $610 deferred.

Information concerning any aspect of this order may be obtained by contacting Lanae Foard, Enforcement Coordinator at (512) 239-2554, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Greif Packaging LLC, Docket No. 2012-1099-IWD-E on January 22, 2013 assessing $800 in administrative penalties with $160 deferred.

Information concerning any aspect of this order may be obtained by contacting Heather Brister, Enforcement Coordinator at (254) 761-3034, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Moulton, Docket No. 2012-1107-PWS-E on January 22, 2013 assessing $168 in administrative penalties with $33 deferred.

Information concerning any aspect of this order may be obtained by contacting Jim Fisher, Enforcement Coordinator at (512) 239-2537, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding KARS INC. dba NW Highway Chevron, Docket No. 2012-1120-PST-E on January 22, 2013 assessing $2,250 in administrative penalties with $450 deferred.

Information concerning any aspect of this order may be obtained by contacting Michael Meyer, Enforcement Coordinator at (512) 239-4492, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding OXID L.P., Docket No. 2012-1136-IWD-E on January 22, 2013 assessing $2,500 in administrative penalties with $500 deferred.

Information concerning any aspect of this order may be obtained by contacting Jacquelyn Green, Enforcement Coordinator at (512) 239-2587, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Itasca Landfill TX, LP, Docket No. 2012-1140-IHW-E on January 22, 2013 assessing $4,825 in administrative penalties with $965 deferred.

Information concerning any aspect of this order may be obtained by contacting Danielle Porras, Enforcement Coordinator at (713) 767-3682, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A field citation was entered regarding Amarillo Independent School District, Docket No. 2012-1176-PST-E on January 22, 2013 assessing $875 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Rebecca Boyett, Enforcement Coordinator at (512) 239-2503, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding M.A.A.A. ENTERPRISES, INC. dba Clinton Food Market, Docket No. 2012-1216-PST-E on January 22, 2013 assessing $5,414 in administrative penalties with $1,082 deferred.

Information concerning any aspect of this order may be obtained by contacting Danielle Porras, Enforcement Coordinator at (713) 767-3682, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding BLACKLANDS INVESTMENT CORPORATION dba Bluff Dale Country Store, Docket No. 2012-1217-PST-E on January 22, 2013 assessing $3,750 in administrative penalties with $750 deferred.

Information concerning any aspect of this order may be obtained by contacting Andrea Park, Enforcement Coordinator at (713) 422-8970, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding RCF Investments, Inc. dba The Brock Junction, Docket No. 2012-1250-PST-E on January 22, 2013 assessing $3,375 in administrative penalties with $675 deferred.

Information concerning any aspect of this order may be obtained by contacting Remington Burklund, Enforcement Coordinator at (512) 239-2611, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding PADMA CORPORATION dba Step N Go, Docket No. 2012-1258-PST-E on January 22, 2013 assessing $3,450 in administrative penalties with $690 deferred.

Information concerning any aspect of this order may be obtained by contacting Andrea Park, Enforcement Coordinator at (713) 422-8970, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Oscar S. Reyes, Docket No. 2012-1265-OSI-E on January 22, 2013 assessing $500 in administrative penalties with $100 deferred.

Information concerning any aspect of this order may be obtained by contacting JR Cao, Enforcement Coordinator at (512) 239-2543, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding WOODLAND OAKS UTILITY, LP formerly known as WOODLAND OAKS UTILITY COMPANY, INC., Docket No. 2012-1283-MWD-E on January 22, 2013 assessing $1,775 in administrative penalties with $355 deferred.

Information concerning any aspect of this order may be obtained by contacting Lanae Foard, Enforcement Coordinator at (512) 239-2554, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Electra, Docket No. 2012-1285-MWD-E on January 22, 2013 assessing $4,850 in administrative penalties with $970 deferred.

Information concerning any aspect of this order may be obtained by contacting Jorge Ibarra, P.E., Enforcement Coordinator at (817) 588-5890, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Knife River Corporation - South, Docket No. 2012-1292-IWD-E on January 22, 2013 assessing $4,800 in administrative penalties with $960 deferred.

Information concerning any aspect of this order may be obtained by contacting JR Cao, Enforcement Coordinator at (512) 239-2543, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Aqua Utilities, Inc. dba Aqua Texas, Inc., Docket No. 2012-1296-PWS-E on January 22, 2013 assessing $3,277 in administrative penalties with $655 deferred.

Information concerning any aspect of this order may be obtained by contacting Jim Fisher, Enforcement Coordinator at (512) 239-2537, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Traversari USA LLC dba Texaco 155, Docket No. 2012-1310-PST-E on January 22, 2013 assessing $3,605 in administrative penalties with $721 deferred.

Information concerning any aspect of this order may be obtained by contacting Rebecca Boyett, Enforcement Coordinator at (512) 239-2503, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Troup, Docket No. 2012-1315-MWD-E on January 22, 2013 assessing $5,425 in administrative penalties with $1,085 deferred.

Information concerning any aspect of this order may be obtained by contacting Nicholas Nevid, Enforcement Coordinator at (512) 239-2612, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding T & C OLIVER LLC dba Oliver's Place, Docket No. 2012-1332-PST-E on January 22, 2013 assessing $4,993 in administrative penalties with $998 deferred.

Information concerning any aspect of this order may be obtained by contacting Joel McAlister, Enforcement Coordinator at (512) 239-2619, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding ROCK CREEK WATER SUPPLY CORPORATION, Docket No. 2012-1372-PWS-E on January 22, 2013 assessing $780 in administrative penalties with $156 deferred.

Information concerning any aspect of this order may be obtained by contacting Katy Schumann, Enforcement Coordinator at (512) 239-2602, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Shawn & Aydin Enterprises, Inc. dba Shawn's Shop N Go, Docket No. 2012-1428-PST-E on January 22, 2013 assessing $5,670 in administrative penalties with $1,134 deferred.

Information concerning any aspect of this order may be obtained by contacting Judy Kluge, Enforcement Coordinator at (817) 588-5825, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding DALE LOWDEN EXCAVATING, INC., Docket No. 2012-1531-WQ-E on January 22, 2013 assessing $1,876 in administrative penalties with $375 deferred.

Information concerning any aspect of this order may be obtained by contacting Heather Brister, Enforcement Coordinator at (254) 761-3034, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Saeb Kutob dba Arp Food Store, Docket No. 2012-1595-PST-E on January 22, 2013 assessing $3,750 in administrative penalties with $750 deferred.

Information concerning any aspect of this order may be obtained by contacting Jessica Schildwachter, Enforcement Coordinator at (512) 239-2617, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A field citation was entered regarding Robert C. Thomas, LLC, Docket No. 2012-2004-WOC-E on January 22, 2013 assessing $175 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Heather Podlipny, Enforcement Coordinator at (512) 239-2603, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A field citation was entered regarding A.D.A. GROUP, INC. dba Chevron 163757, Docket No. 2012-2019-PST-E on January 22, 2013 assessing $875 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Maggie Dennis, Enforcement Coordinator at (512) 239-2578, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A field citation was entered regarding IASIS HEALTHCARE CORPORATION dba Odessa Regional Medical Center, Docket No. 2012-2030-PST-E on January 22, 2013 assessing $2,625 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Rebecca Boyett, Enforcement Coordinator at (512) 239-2503, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A field citation was entered regarding Prestonwood Golf Club LLC, Docket No. 2012-2040-PST-E on January 22, 2013 assessing $875 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Maggie Dennis, Enforcement Coordinator at (512) 239-2578, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A field citation was entered regarding SAFEWAY, INC., Docket No. 2012-2041-PST-E on January 22, 2013 assessing $875 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Maggie Dennis, Enforcement Coordinator at (512) 239-2578, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding James S. Scroggins, Docket No. 2011-0337-IHW-E on January 25, 2013 assessing $1,020 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Peipey Tang, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding RHIMCO INDUSTRIES, INC., Docket No. 2011-0637-WQ-E on January 25, 2013 assessing $1,020 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jim Sallans, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Valley Assets Holding, Inc. dba Lucky 88, Docket No. 2011-1337-PST-E on January 25, 2013 assessing $3,500 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jim Sallans, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Luis Escobedo dba Pallet Services, Docket No. 2011-1777-MLM-E on January 25, 2013 assessing $2,868 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Kari L. Gilbreth, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Yushra Investment, Inc. dba Store T24 #2, Docket No. 2011-1801-PST-E on January 25, 2013 assessing $2,379 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Elizabeth Lieberknecht, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Ahmed Abu-Alghanam dba Energy Exxon, Docket No. 2011-2004-PST-E on January 25, 2013 assessing $2,500 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Kari L. Gilbreth, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding PLEWDAWGS MARKET LLC, Docket No. 2011-2007-PST-E on January 25, 2013 assessing $2,400 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Anna Treadwell, Staff Attorney at (512) 239-3400, Texas

Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Tristar Convenience Stores, Inc. dba Handi Stop 65, Docket No. 2011-2176-PST-E on January 25, 2013 assessing $3,950 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jim Sallans, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding KAPADIA SADLER DEVELOPMENT, INC. dba Kidd Jones 11, Docket No. 2012-0138-PST-E on January 25, 2013 assessing $2,637 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Joel Cordero, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Pokhara Corporation, Docket No. 2012-0444-PST-E on January 25, 2013 assessing $5,131 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Rebecca M. Combs, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Aldine Independent School District, Docket No. 2012-0537-PST-E on January 25, 2013 assessing $2,950 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Rebecca M. Combs, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding SHEEMA ENTERPRISE, INC. dba Highway 59 Phillips 66, Docket No. 2012-0721-PST-E on January 25, 2013 assessing $3,000 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Ryan Rutledge, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding THALJI ENTERPRISES, INC. dba La Marque Mobil, Docket No. 2012-0987-PST-E on January 25, 2013 assessing $2,954 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Joel Cordero, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

TRD-201300474
Bridget C. Bohac
Chief Clerk
Texas Commission on Environmental Quality
Filed: February 6, 2013

♦ ♦ ♦

Notice of District Petition

Notices issued January 30, 2013.

TCEQ Internal Control No. D-12032012-003; Magnolia 1138, Ltd., a Texas limited partnership; Marshall Timber and Reality, LLC, a Texas limited liability company, general partner William L. Liles, Jr. ("Petitioner") filed a petition for creation of Montgomery County Water Control & Improvement District No. 4 (District) with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, Section 59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative Code Chapter 293; and the procedural rules of the TCEQ. The petition states the following: (1) the Petitioner is the owner of a majority in value of the land to be included in the proposed District; (2) there are no lienholders on the property to be included in the proposed District; (3) the proposed District will contain approximately 382.64 acres located in Montgomery County, Texas; and (4) the proposed District is within the extraterritorial jurisdiction of the City of Magnolia, Texas, and no portion of land within the proposed District is within the corporate limits or extraterritorial jurisdiction of any other city, town or village in Texas. By Ordinance No. R-2012-016, effective July 10, 2012, the City of Magnolia, Texas, gave its consent to the creation of the proposed District, pursuant to Texas Water Code §54.016 and authorized the Petitioner to initiate proceedings to create this political subdivision within its jurisdiction. According to the petition, a preliminary investigation has been made to determine the cost of the project, and it is estimated by the petitioner, from the information available at this time, that the cost of said project will be approximately $20,944,000 ($14,759,000 detention and drainage plus $6,185,000 recreation).

TCEQ Internal Control No. D-12032012-004; Magnolia 1138, Ltd. ("Petitioner") filed a petition for creation of Montgomery County Municipal Utility District No. 131 (District) with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, Section 59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative Code Chapter 293; and the procedural rules of the TCEQ. The petition states the following: (1) the Petitioner is the owner of a majority in value of the land to be included in the proposed District; (2) there are no lienholders on the property to be included in the proposed District; (3) the proposed District will contain approximately 758.196 acres located in Montgomery County, Texas; and (4) the proposed District is within the extraterritorial jurisdiction of the City of Magnolia, Texas, and no portion of land within the proposed District is within the corporate limits or extraterritorial jurisdiction of any other city, town or village in Texas. By Ordinance No. R-2012-015, effective July 10, 2012, the City of Magnolia, Texas, gave its consent to the creation of the proposed District, pursuant to Texas Water Code §54.016 and authorized the Petitioner to initiate proceedings to create this political subdivision within its jurisdiction. According to the petition, a preliminary investigation has been made to determine the cost of the project, and it is estimated by the petitioner, from the information available at this time, that the cost of said project will be approximately $46,540,750 ($34,295,000 for utilities plus $3,414,750 for recreational facilities plus $8,831,000 for roads).

INFORMATION SECTION

To view the complete issued notice, view the notice on our web site at www.tceq.texas.gov/comm_exec/cc/pub_notice.html or call the Office of the Chief Clerk at (512) 239-3300 to obtain a copy of the complete notice. When searching the web site, type in the issued date range shown at the top of this document to obtain search results.

The TCEQ may grant a contested case hearing on the petition if a written hearing request is filed within 30 days after the newspaper publication of the notice. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) the name of the Petitioner and the TCEQ Internal Control Number; (3) the statement "I/we request a contested case hearing"; (4) a brief description of how you would be affected by the

petition in a way not common to the general public; and (5) the location of your property relative to the proposed District's boundaries. You may also submit your proposed adjustments to the petition. Requests for a contested case hearing must be submitted in writing to the Office of the Chief Clerk at the address provided in the information section below. The Executive Director may approve the petition unless a written request for a contested case hearing is filed within 30 days after the newspaper publication of this notice. If a hearing request is filed, the Executive Director will not approve the petition and will forward the petition and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting. If a contested case hearing is held, it will be a legal proceeding similar to a civil trial in state district court. Written hearing requests should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address. For additional information, individual members of the general public may contact the Districts Review Team, at (512) 239-4691. Si desea información en español, puede llamar al (512) 239-0200. General information regarding TCEQ can be found at our web site at www.tceq.texas.gov.

TRD-201300473
Bridget C. Bohac
Chief Clerk
Texas Commission on Environmental Quality
Filed: February 6, 2013

♦ ♦ ♦

Notice of Opportunity to Comment on Agreed Orders of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ, agency, or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (TWC), §7.075. TWC, §7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. TWC, §7.075 requires that notice of the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **March 18, 2013.** TWC, §7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the attorney designated for the AO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on March 18, 2013.** Comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The designated attorney is available to discuss the AO and/or the comment procedure at the listed phone number; however, TWC, §7.075 provides that comments on an AO shall be submitted to the commission in **writing.**

(1) COMPANY: City of Cotulla; DOCKET NUMBER: 2012-0907-PWS-E; TCEQ ID NUMBER: RN101384550; LOCATION: 117 North Front Street, Cotulla, La Salle County; TYPE OF FACILITY: municipal public water system; RULES VIOLATED: Texas Health and Safety Code, §341.0351 and 30 TAC §290.39(j), by failing to notify the executive director prior to making any significant change to the facility's production, treatment, storage, pressure maintenance or distribution system; 30 TAC §290.43(c)(3), by failing to provide the overflow on the ground storage tank (GST) with a gravity-hinged and weighted cover that fits tightly with no gap over 1/16 inch; 30 TAC §290.43(c)(4), by failing to provide all water storage tanks with a water level indicator located at the tank site; 30 TAC §290.44(h)(1)(B)(i), by failing to establish an adequate internal cross-connection control program; 30 TAC §290.46(e)(4)(C), by failing to employ at least two operators who hold a Class C or higher groundwater license and who each work at least 16 hours per month at the public water system's production, treatment, and distribution facilities; 30 TAC §290.46(i), by failing to adopt an adequate plumbing ordinance, regulations, or service agreement with provisions for proper enforcement to ensure that neither cross-connections nor other unacceptable plumbing practices are permitted; 30 TAC §290.46(f)(2) and (3)(E)(iv), by failing to make water works operations and maintenance records available for review by commission personnel during the investigation; 30 TAC §290.46(m), by failing to initiate maintenance and housekeeping practices to ensure the good working condition and general appearance of the system's facilities and equipment; 30 TAC §290.46(m)(1)(A), by failing to inspect the GSTs annually; 30 TAC §290.46(m)(4), by failing to maintain all distribution system lines, storage and pressure maintenance facilities, water treatment units and all related appurtenances in a watertight condition; 30 TAC §290.46(n)(1), by failing to maintain accurate and up-to-date as-built plans or record drawings and specifications for each treatment plant, pump station, and storage tank; 30 TAC §290.121(a) and (b), by failing to maintain an up-to-date chemical and microbiological monitoring plan; and 30 TAC §290.41(c)(3)(O), by failing to enclose the well with an intruder-resistant fence with a lockable gate or a locked and ventilated well house; PENALTY: $2,694; STAFF ATTORNEY: Kari L. Gilbreth, Litigation Division, MC 175, (512) 239-1320; REGIONAL OFFICE: Laredo Regional Office, 707 East Calton Road, Suite 304, Laredo, Texas 78041-3887, (956) 791-6611.

(2) COMPANY: Crouch's Cleaners, Inc. DBA Comet Cleaners; DOCKET NUMBER: 2012-0163-MLM-E; TCEQ ID NUMBER: RN102215704; LOCATION: 2700 Richmond Road, Suite 10B, Texarkana, Bowie County; TYPE OF FACILITY: dry cleaning facility; RULES VIOLATED: 30 TAC §337.21(a), by failing to ensure the proper disposal of dry cleaning wastes; and 30 TAC §337.20(e)(6), by failing to perform weekly visual inspections of each secondary containment structure; PENALTY: $650; STAFF ATTORNEY: Tammy Mitchell, Litigation Division, MC 175, (512) 239-0736; REGIONAL OFFICE: Tyler Regional Office, 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(3) COMPANY: DASS INVESTMENTS, LLC d/b/a Pepes Grocery Store; DOCKET NUMBER: 2012-1389-PST-E; TCEQ ID NUMBER: RN102792355; LOCATION: 4239 United States Highway 83, San Ygnacio, Zapata County; TYPE OF FACILITY: underground storage tank (UST) system and convenience store with retail sales of gasoline; RULES VIOLATED: TWC, §26.3475(d) and 30 TAC §334.49(a)(1), by failing to provide proper corrosion protection for the UST system; PENALTY: $5,625; STAFF ATTORNEY: Mike Fishburn, Litigation Division, MC 175, (512) 239-0635; REGIONAL OFFICE: Laredo Regional Office, 707 East Calton Road, Suite 304, Laredo, Texas 78041-3887, (956) 791-6611.

(4) COMPANY: Edgar Gerald Alford and United Oilfield Construction LLC; DOCKET NUMBER: 2011-1442-AIR-E; TCEQ ID NUMBER:

RN105696652 and RN105696637; LOCATION: 1901 Melissa Lane, Cleburne, Johnson County; TYPE OF FACILITY: portable trench burners; RULES VIOLATED: 30 TAC §122.143(4) and §122.46(2), Texas Health and Safety Code (THSC), §382.085(b), and Federal Operating Permit (FOP) Number 03280/General Operating Permit (GOP) Number 518, Terms and Conditions (b)(2) and (3)(D)(ii), by failing to submit a Permit Compliance Certification (PCC) for Trench Burner Number 1 within 30 days after the end of the certification period; 30 TAC §112.143(4) and §122.145(2)(C), THSC, §382.085(b), and FOP Number 03280/GOP Number 518, Terms and Conditions (b)(2) and (3)(C)(ii), by failing to submit a semi-annual deviation report for Trench Burner Number 1 within 30 days after the end of the reporting period; 30 TAC §122.143(4) and §122.146(2), THSC, §382.085(b), and FOP Number 03280/GOP Number 518, Terms and Conditions (b)(2) and (3)(D)(ii), by failing to submit a PCC for Trench Burner Number 2 within 30 days after the end of the certification period; and 30 TAC §112.143(4) and §122.145(2)(C), THSC, §382.085(b), and FOP Number 03280/GOP Number 518, Terms and Conditions (b)(2) and (3)(C)(ii); PENALTY: $4,200; STAFF ATTORNEY: Jeffrey Huhn, Litigation Division, MC R-13, (403) 403-4023; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(5) COMPANY: Juan Meza d/b/a Red X Truck Stop; DOCKET NUMBER: 2011-1129-PST-E; TCEQ ID NUMBER: RN102353117; LOCATION: 5934 West Interstate 20, Odessa, Ector County; TYPE OF FACILITY: underground storage tank (UST) system and convenience store with retail sales of gasoline; RULES VIOLATED: TWC, §26.3467 and 30 TAC §334.8(c)(5)(A)(i), by failing to make available to a common carrier a valid, current TCEQ delivery certificate before accepting delivery of a regulated substance into the USTs; 30 TAC §334.7(d)(3), by failing to notify the executive director of any change or additional information regarding USTs within 30 days from the date of the occurrence of the change; 30 TAC §334.8(c)(4)(C), by failing to obtain a UST delivery certificate by submitting a properly completed new UST registration and self-certification form at least 30 days prior to the ownership change; 30 TAC §37.815(a) and (b), by failing to demonstrate acceptable financial assurance for taking corrective action and for compensating third parties for bodily injury and property damage caused by accidental releases arising from the operation of petroleum USTs; TWC, §26.3475(d) and 30 TAC §334.49(a)(1), by failing to provide proper corrosion protection for the UST system; TWC, §26.3475(c)(1) and 30 TAC §334.50(b)(1)(A), by failing to monitor the USTs for releases at a frequency of at least once per month (not to exceed 35 days between each monitoring; and TWC, §26.3475(a) and 30 TAC §334.50(b)(2), by failing to provide a method of release detection for the piping associated with the UST system; PENALTY: $28,234; STAFF ATTORNEY: Rudy Calderon, Litigation Division, MC 175, (512) 239-0205; REGIONAL OFFICE: Midland Regional Office, 3300 North A Street, Building 4, Suite 107, Midland, Texas 79705-5406, (432) 570-1359.

(6) COMPANY: Sand Hill Foundation, LLC; DOCKET NUMBER: 2012-1069-AIR-E; TCEQ ID NUMBER: RN106175615; LOCATION: 1300 North East Loop, Carthage, Panola County; TYPE OF FACILITY: oil field and heavy construction equipment yard; RULES VIOLATED: Texas Health and Safety Code, §382.085(b) and 30 TAC §101.4, by failing to prevent nuisance dust emissions from impacting off property receptors; PENALTY: $1,400; STAFF ATTORNEY: Jeffrey Huhn, Litigation Division, MC R-13, (403) 403-4023; REGIONAL OFFICE: Tyler Regional Office, 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(7) COMPANY: SODA WATER SUPPLY CORPORATION; DOCKET NUMBER: 2012-1725-PWS-E; TCEQ ID NUMBER: RN101221315; LOCATION: United States Highway 190 West, approximately 0.5 miles from United States Highway 59 intersection, Livingston, Polk County; TYPE OF FACILITY: public water system; RULES VIOLATED: 30 TAC §290.14(c)(1)(F) and TCEQ Default Order Docket Number 2010-1010-PWS-E, Ordering Provision 3.c., by failing to provide sanitary control easements covering land within 150 feet of each well; 30 TAC §290.46(m), by failing to initiate maintenance and housekeeping practices to ensure the good working condition and general appearance of the facility and its equipment; 30 TAC §290.41(c)(3)(O), by failing to provide an intruder-resistant fence, 30 TAC §290.46(f)(2) and (3)(A)(iv), by failing to provide water system records to commission personnel at the time of the investigation; and 30 TAC §290.121(b), by failing to provide adequate up-to-date chemical and microbiological monitoring plan; PENALTY: $510; STAFF ATTORNEY: Mike Fishburn, Litigation Division, MC 175, (512) 239-0635; REGIONAL OFFICE: Beaumont Regional Office, 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(8) COMPANY: S S S ENTERPRISES, INC. d/b/a On The Go Mart; DOCKET NUMBER: 2012-0572-PST-E; TCEQ ID NUMBER: RN101822039; LOCATION: 8901 Howard Drive, Houston, Harris County; TYPE OF FACILITY: underground storage tank (UST) system and convenience store with retail gasoline sales; RULES VIOLATED: TWC, §26.3475(d) and 30 TAC §334.49(a)(1), by failing to provide proper corrosion protection for the UST system; TWC, §26.3475(a) and (c)(1) and 30 TAC §334.50(b)(1)(A) and (2), by failing to monitor the USTs for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring), and by failing to provide release detection for the piping associated with the UST system; and 30 TAC §334.10(b)(1)(B), by failing to maintain all UST records and make them immediately available for inspection upon request by agency personnel; PENALTY: $8,120; STAFF ATTORNEY: Becky Combs, Litigation Division, MC 175, (512) 239-6939; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(9) COMPANY: Zarina Enterprises, Inc. d/b/a EZ Truck Stop; DOCKET NUMBER: 2012-1199-PST-E; TCEQ ID NUMBER: RN102457116; LOCATION: Highway 59 Hungerford Bypass, Wharton, Wharton County; TYPE OF FACILITY: underground storage tank (UST) system and convenience store with retail sales of gasoline; RULES VIOLATED: TWC, §26.3475(d) and 30 TAC §334.49(a)(1), by failing to provide proper corrosion protection for the UST system; PENALTY: $2,813; STAFF ATTORNEY: Becky Combs, Litigation Division, MC 175, (512) 239-6939; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

TRD-201300460
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: February 5, 2013

♦ ♦ ♦

Notice of Opportunity to Comment on Default Orders of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Default Orders (DOs). The commission staff proposes a DO when the staff has sent an executive director's preliminary report and petition (EDPRP) to an entity outlining the alleged violations; the proposed penalty; the proposed technical requirements necessary to bring the entity back into compliance; and the entity fails to request a hearing on the matter within 20 days of its receipt of the EDPRP or requests

a hearing and fails to participate at the hearing. Similar to the procedure followed with respect to Agreed Orders entered into by the executive director of the commission, in accordance with Texas Water Code (TWC), §7.075 this notice of the proposed order and the opportunity to comment is published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **March 18, 2013.** The commission will consider any written comments received and the commission may withdraw or withhold approval of a DO if a comment discloses facts or considerations that indicate that consent to the proposed DO is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction, or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed DO is not required to be published if those changes are made in response to written comments.

A copy of each proposed DO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about the DO should be sent to the attorney designated for the DO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on March 18, 2013.** Comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The commission's attorneys are available to discuss the DOs and/or the comment procedure at the listed phone numbers; however, §7.075 provides that comments on the DOs shall be submitted to the commission in **writing.**

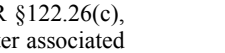
(1) COMPANY: J & J Soil Service, Inc.; DOCKET NUMBER: 2012-1423-MLM-E; TCEQ ID NUMBER: RN106451776; LOCATION: 409 Farm-to-Market Road 2423, Grapeland, Houston County; TYPE OF FACILITY: aglime, dry and liquid fertilizer, and pasture spraying facility with above-ground storage tanks (AST); RULES VIOLATED: 30 TAC §324.4(2)(B), by failing to prevent an unauthorized discharge of used oil; 30 TAC §324.6 and 40 Code of Federal Regulations (CFR) §279.22(c)(1), by failing to label or clearly mark containers used to store used oil; TWC, §26.121(a), by failing to prevent the discharge of industrial waste into or adjacent to water in the state; 30 TAC §281.25(a)(4) and 40 CFR §122.26(c), by failing to obtain authorization to discharge storm water associated with industrial activities under Texas Pollutant Discharge Elimination System Multi-Sector General Permit Number TXR050000; and 30 TAC §334.127(a), by failing to register ASTs; PENALTY: $12,250; STAFF ATTORNEY: Kari L. Gilbreth, Litigation Division, MC 175, (512) 239-1320; REGIONAL OFFICE: Beaumont Regional Office, 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(2) COMPANY: LONE STAR DISTRIBUTORS, INC. d/b/a Hectors Drive In; DOCKET NUMBER: 2012-1386-PST-E; TCEQ ID NUMBER: RN102042447; LOCATION: 131 North Avenue, Donna, Hidalgo County; TYPE OF FACILITY: underground storage tank (UST) system and convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §37.815(a) and (b), by failing to demonstrate acceptable financial assurance for taking corrective action and for compensating third parties for bodily injury and property damage caused by accidental releases arising from the operation of the petroleum USTs; TWC, §26.3475(d) and 30 TAC §334.49(a)(1), by failing to provide proper corrosion protection for the UST system; TWC, §26.3475(b) and (c)(1) and 30 TAC §334.50(b)(1)(A) and (2), by failing to monitor for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring), and by failing to provide release detection for the piping associated with the USTs; and 30 TAC §334.10(b), by failing to maintain UST records and make them immediately available for inspection upon request by agency personnel; PENALTY: $12,781; STAFF ATTORNEY: Becky Combs, Litigation Division, MC 175, (512) 239-6939; REGIONAL OFFICE: Harlingen Regional Office, 1804 West Jefferson Avenue, Harlingen, Texas 78550-5247, (956) 425-6010.

(3) COMPANY: NSRS ENTERPRISE, INC. d/b/a DON'S FOOD MART; DOCKET NUMBER: 2012-0755-PST-E; TCEQ ID NUMBER: RN101432755; LOCATION: 2020 East Rusk Street, Jacksonville, Cherokee County; TYPE OF FACILITY: underground storage tank (UST) system and a convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.8(c)(4)(A)(vii) and (5)(B)(ii), by failing to renew a previously issued UST delivery certificate by submitting a properly completed UST registration and self-certification form at least 30 days before the expiration date; TWC, §26.3467(a) and 30 TAC §334.8(c)(5)(A)(i), by failing to make available to a common carrier a valid, current TCEQ delivery certificate before accepting delivery of a regulated substance into the USTs; and TWC, §26.3475(c)(1) and 30 TAC §334.50(b)(1)(A), by failing to monitor the USTs for releases at a frequency of at least once per month (not to exceed 35 days between each monitoring); PENALTY: $4,000; STAFF ATTORNEY: Becky Combs, Litigation Division, MC 175, (512) 239-6939; REGIONAL OFFICE: Tyler Regional Office, 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(4) COMPANY: Paul K. Hawkins; DOCKET NUMBER: 2012-0605-LII-E; TCEQ ID NUMBER: RN103597001; LOCATION: Manor, Travis County; TYPE OF FACILITY: landscaping business; RULES VIOLATED: TWC, §37.003, Texas Occupational Code, §1903.251, and 30 TAC §30.5(a), by failing to hold an irrigator license prior to selling, designing, consulting, installing, altering, repairing, or servicing an irrigation system; PENALTY: $861; STAFF ATTORNEY: Jacquelyn Boutwell, Litigation Division, MC 175, (512) 239-5846; REGIONAL OFFICE: Austin Regional Office, Post Office Box 13087, MC R-11, Austin, Texas 78711, (512) 339-2929.

TRD-201300461
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: February 5, 2013



Notice of Opportunity to Comment on Shutdown/Default Orders of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Shutdown/Default Orders (S/DOs). Texas Water Code (TWC), §26.3475 authorizes the commission to order the shutdown of any underground storage tank (UST) system found to be noncompliant with release detection, spill and overfill prevention, and/or, after December 22, 1998, cathodic protection regulations of the commission, until such time as the owner/operator brings the UST system into compliance with those regulations. The commission proposes a Shutdown Order after the owner or operator of a UST facility fails to perform required corrective actions within 30 days after receiving notice of the release detection, spill and overfill prevention, and/or, after December 22, 1998, cathodic protection violations documented at the facility. The commission proposes a Default Order when the staff has sent an executive director's preliminary report and petition (EDPRP) to an entity outlining the alleged violations; the proposed penalty; and the proposed technical requirements necessary to bring the entity back into compliance; and the entity fails to request a hearing on the matter within 20 days of its receipt of the EDPRP or requests a hearing and fails to participate at the hearing. In accordance with TWC, §7.075, this notice of the proposed order and the opportunity to comment is published in the

Texas Register no later than the 30th day before the date on which the public comment period closes, which in this case is **March 18, 2013.** The commission will consider any written comments received and the commission may withdraw or withhold approval of an S/DO if a comment discloses facts or considerations that indicate that consent to the proposed S/DO is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction, or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed S/DO is not required to be published if those changes are made in response to written comments.

Copies of each of the proposed S/DO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about the S/DO shall be sent to the attorney designated for the S/DO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on March 18, 2013.** Written comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The commission attorneys are available to discuss the S/DOs and/or the comment procedure at the listed phone numbers; however, comments on the S/DOs shall be submitted to the commission in **writing.**

(1) COMPANY: ASMA C-STORES, INC. d/b/a Huntsville Exxon; DOCKET NUMBER: 2012-1374-PST-E; TCEQ ID NUMBER: RN102400769; LOCATION: 558 Interstate 45 South, Huntsville, Walker County; TYPE OF FACILITY: UST system and a convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.8(c)(4)(A)(vii) and (5)(B)(ii), by failing to renew a previously issued UST delivery certificate by submitting a properly completed UST registration and self-certification form at least 30 days before the expiration date; TWC, §26.3476(a) and 30 TAC §334.8(c)(5)(A)(i), by failing to make available to a common carrier a valid, current TCEQ delivery certificate before accepting delivery of a regulated substance into the USTs; and TWC, §26.3475(a) and 30 TAC §334.50(b)(2), by failing to provide release detection for the pressurized piping associated with the UST system; PENALTY: $36,495; STAFF ATTORNEY: Becky Combs, Litigation Division, MC 175, (512) 239-6939; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(2) COMPANY: KHODLE, INC.; DOCKET NUMBER: 2012-0563-PST-E; TCEQ ID NUMBER: RN102348919; LOCATION: 7425 Mainland Drive, San Antonio, Bexar County; TYPE OF FACILITY: UST system and convenience store with retail sales of gasoline; RULES VIOLATED: TWC, §26.3475(c)(1) and 30 TAC §334.50(b)(1)(A), by failing to monitor the USTs for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $2,500; STAFF ATTORNEY: Becky Combs, Litigation Division, MC 175, (512) 239-6939; REGIONAL OFFICE: San Antonio Regional Office, 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(3) COMPANY: Luis Nieto d/b/a Nieto's Drive Thru 6; DOCKET NUMBER: 2012-0585-PST-E; TCEQ ID NUMBER: RN104747050; LOCATION: intersection of Farm-to-Market 493 and Laurel Court, Donna, Hidalgo County; TYPE OF FACILITY: UST system and convenience store with retail sales of gasoline; RULES VIOLATED: TWC, §26.3475(d) and 30 TAC §334.49(a)(1), by failing to provide proper corrosion protection for the UST system; and TWC, §26.3475(a) and (c)(1) and 30 TAC §334.50(b)(1)(A) and (2), by failing to monitor the USTs for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring), and by failing to provide proper release detection for the product piping associated with the UST system; PENALTY: $5,134; STAFF ATTORNEY: David Terry, Litigation Division, MC 175, (512) 239-0619; REGIONAL OFFICE: Harlingen Regional Office, 1804 West Jefferson Avenue, Harlingen, Texas 78550-5247, (956) 425-6010.

(4) COMPANY: Yaser Belbisi d/b/a Econo Lube N Tune and Brakes, and Mohamed Hafsi d/b/a Econo Lube N Tune and Brakes; DOCKET NUMBER: 2012-1336-PST-E; TCEQ ID NUMBER: RN102041910; LOCATION: 9003 Huebner Road, San Antonio, Bexar County; TYPE OF FACILITY: used oil UST and an automotive maintenance and repair facility; RULES VIOLATED: TWC, §26.3475(c)(1) and 30 TAC §334.50(b)(1)(A), by failing to monitor the UST for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); TWC, §26.3475(a) and 30 TAC §334.50(b)(2), by failing to provide release detection for the piping associated with the UST system; and 30 TAC §334.10(b), by failing to maintain UST records and make them immediately available for inspection upon request by agency personnel; PENALTY: $5,908; STAFF ATTORNEY: Phillip Goodwin, Litigation Division, MC 175, (512) 239-0675; REGIONAL OFFICE: San Antonio Regional Office, 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

TRD-201300462
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: February 5, 2013

♦ ♦ ♦

Notice of Public Hearing on the Proposed Revision to 30 TAC Chapter 297

The Texas Commission on Environmental Quality (commission) will conduct a public hearing to receive testimony regarding the proposed revision to 30 Texas Administrative Code (TAC) Chapter 297, Water Rights, Substantive, §297.1, under the requirements of Texas Water Code, §5.103, and Texas Government Code, Chapter 2001, Subchapter B.

The proposed rulemaking would amend the definition of "Municipal use" in §297.1(32) to allow use of return flows authorized under Texas Water Code, §11.042, for watering of parks, golf courses, and parkways as a municipal use, after that use of return flows has been authorized by the commission. The proposed rulemaking would also expand the authorized uses to include the watering of other public or recreational spaces.

The commission will hold a public hearing on this proposal in Austin on March 12, 2013, at 10:00 a.m. in Building E, Room 201S, at the commission's central office located at 12100 Park 35 Circle. The hearing is structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. Open discussion will not be permitted during the hearing; however, commission staff members will be available to discuss the proposal 30 minutes prior to the hearing.

Persons who have special communication or other accommodation needs who are planning to attend the hearing should contact Sandy Wong, Office of Legal Services, at (512) 239-1802. Requests should be made as far in advance as possible.

Written comments may be submitted to Michael Parrish, MC 205, Office of Legal Services, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087 or faxed to (512) 239-4808. Electronic comments may be submitted at: *http://www5.tceq.texas.gov/rules/ecomments/.* File size restrictions may apply to comments being submitted via the *eComments*

system. All comments should reference Rule Project Number 2012-039-297-OW. The comment period closes March 18, 2013. Copies of the proposed rulemaking can be obtained from the commission's Web site at *http://www.tceq.texas.gov/nav/rules/propose_adopt.html.* For further information, please contact Jennifer Allis, Water Rights Permitting and Availability Section, at (512) 239-0027.

TRD-201300390
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Filed: February 1, 2013

♦ ♦ ♦

Notice of Public Hearing on Proposed Revisions to 30 TAC Chapter 336

The Texas Commission on Environmental Quality (commission) will conduct a public hearing to receive testimony regarding proposed new 30 Texas Administrative Code (TAC) Chapter 336, Radioactive Substance Rules, §336.227, under the requirements of Texas Government Code, Chapter 2001, Subchapter B.

The proposed rulemaking would exempt minimal amounts of licensed radioactive tracers used in the exploration, development or production of oil and gas resources from TCEQ low-level radioactive waste licensing and disposal requirements.

The commission will hold a public hearing on this proposal in Austin on March 5, 2013, at 10:00 a.m. in Building E, Room 201S, at the commission's central office located at 12100 Park 35 Circle. The hearing is structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. Open discussion will not be permitted during the hearing; however, commission staff members will be available to discuss the proposal 30 minutes prior to the hearing.

Persons who have special communication or other accommodation needs who are planning to attend the hearing should contact Sandy Wong, Office of Legal Services, at (512) 239-1802. Requests should be made as far in advance as possible.

Written comments may be submitted to Bruce McAnally, MC 205, Office of Legal Services, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087 or faxed to (512) 239-4808. Electronic comments may be submitted at: *http://www5.tceq.texas.gov/rules/ecomments/.* File size restrictions may apply to comments being submitted via the *eComments* system. All comments should reference Rule Project Number 2013-010-336-WS. The comment period closes March 18, 2013. Copies of the proposed rulemaking can be obtained from the commission's Web site at: *http://www.tceq.texas.gov/nav/rules/propose_adopt.html.* For further information, please contact Hans Weger, Radioactive Materials Unit, (512) 239-6465.

TRD-201300388
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Filed: February 1, 2013

♦ ♦ ♦

Notice of Water Quality Applications

The following notices were issued on January 25, 2013 through February 1, 2013.

The following require the applicants to publish notice in a newspaper. Public comments, requests for public meetings, or requests for a contested case hearing may be submitted to the Office of the Chief Clerk, Mail Code 105, P.O. Box 13087, Austin, Texas 78711-3087, WITHIN 30 DAYS OF THE DATE OF NEWSPAPER PUBLICATION OF THE NOTICE.

INFORMATION SECTION

NAVASOTA WHARTON ENERGY PARTNERS LP which operates Colorado Bend Energy Center, a natural gas-fired combined-cycle power generation facility, has applied to the Texas Commission on Environmental Quality (TCEQ) for a major amendment to Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0004781000 to authorize an increase in the daily average flow limitation from 1,078,000 gallons per day to 1,650,000 gallons per day at Outfall 001; and an increase in the daily maximum flow limitation from 1,200,000 gallons per day to 1,850,000 gallons per day at Outfall 001; and to revise the free available chlorine sample type from composite to grab at Outfall 001. The current permit authorizes the discharge of cooling tower blowdown commingled with contact storm water and previously monitored effluent at a daily average flow not to exceed 1,078,000 gallons per day via Outfall 001; metal cleaning waste on an intermittent and flow variable basis via internal Outfall 101; and low volume waste and contact storm water via internal Outfall 201. The facility is located 1.4 miles southwest of the city limits of Wharton, Texas and adjacent to and north of State Highway 60 and approximately 0.75 miles southwest of County Road 3012, Wharton County, Texas.

MARSHALL MINE LLC which proposes to operate the Marshall Mine, a surface lignite coal mining operation, has applied for new permit TPDES Permit No. WQ0004987000 to authorize the discharge of stormwater runoff, mine depressurization water, and mine pit water from ponds from active mining areas via Outfalls 001, 002, 003, 004, 005, and 006 on an intermittent and flow variable basis during the active mining phase; and stormwater runoff via Outfalls 001, 002, 003, 004, 005, and 006 on an intermittent and flow variable basis during the post mining phase. The facility is located at 3900 Farm-to-Market Road 1186, north of the Sabine River and east of State Highway 59 in south Harrison County and north Panola County, approximately 15 miles south of the City of Marshall, Texas, 75672 and 75639.

CITY OF LA MARQUE has applied for a renewal of TPDES Permit No. WQ0010410003, which authorizes the discharge of treated domestic wastewater (OR filter backwash effluent from a water treatment plant) at an annual average flow not to exceed 3,000,000 gallons per day. The facility is located adjacent to Mahan Park approximately 1,300 feet south of the intersection of Woodland and Lake Streets, on North Bank of Highland Bayou in Galveston County, Texas.

HARRIS COUNTY MUNICIPAL UTILITY DISTRICT NO 26 has applied for a renewal of TPDES Permit No. WQ0011406001, which authorizes the discharge of treated domestic wastewater at an annual average flow not to exceed 1,500,000 gallons per day. The facility is located at 21615 Dawn Timbers Court, Humble, Texas, approximately 3,500 feet east of the confluence of Spring Creek and Cypress Creek, and 9,400 feet north of Farm-to-Market Road 1960 in Harris County, Texas 77338.

TRINITY BAY CONSERVATION DISTRICT has applied for a renewal of TPDES Permit No. WQ0011537001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 100,000 gallons per day. The facility is located approximately 470 feet north of Eagle Road, approximately 570 feet east of the West Bayshore Road in Oak Island, in Chambers County, Texas 77514.

HARRIS COUNTY MUNICIPAL UTILITY DISTRICT NO 82 has applied for a renewal of TPDES Permit No. WQ0011799001, which

authorizes the discharge of treated domestic wastewater at an annual average flow not to exceed 2,200,000 gallons per day. The facility is located approximately 1.5 miles east of Aldine-Westfield Road and approximately 3 miles north of Farm-to-Market Road 1960 at 2400 Domino Road in Harris County, Texas 77373.

WOODGATE MOBILE HOME VILLAGE INC has applied for a renewal of TPDES Permit No. 12414-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 35,000 gallons per day. The plant site is located approximately 0.25 mile west of the intersection of Veterans Memorial Drive and Frick Road on the south side of Frick Road in Harris County, Texas.

DUCO INC has applied for a renewal of TPDES Permit No. 12874-001 which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 10,000 gallons per day. The facility is located at 16661 Jacintoport Boulevard in Harris County, Texas.

CITY OF COMANCHE has applied for a renewal of TPDES Permit No. WQ0014445001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 595,000 gallons per day. The facility is located southeast of the intersection of Fleming Avenue and Park Street and north of Indian Creek in Comanche County, Texas 76442.

The following do not require publication in a newspaper. Written comments or requests for a public meeting may be submitted to the Office of the Chief Clerk, at the address provided above, WITHIN 30 DAYS OF THE ISSUED DATE OF THE NOTICE.

THE TEXAS COMMISSION ON ENVIRONMENTAL QUALITY staff has initiated a minor amendment of the TPDES Permit No. WQ0011837001 issued to City of Oyster Creek, to require the monitoring of influent Biochemical Oxygen Demand due to the facility accepting septage, port-a-potty waste and landfill lechate. The existing permit authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 500,000 gallons per day. The facility is located at 2514 East Highway 332, approximately 1.6 miles southeast of the intersection of State Highway 332 and Farm-to-Market Road 523, at the intersection of State Highway 332 and the U.S. Corps of Engineers Flood Control Levee on the west side of the levee in Brazoria County, Texas 77541.

If you need more information about these permit applications or the permitting process, please call the TCEQ Public Education Program, toll free, at 1-800-687-4040. General information about the TCEQ can be found at our web site at www.tceq.texas.gov. Si desea información en español, puede llamar al 1-800-687-4040.

TRD-201300472
Bridget C. Bohac
Chief Clerk
Texas Commission on Environmental Quality
Filed: February 6, 2013

♦ ♦ ♦

Texas Ethics Commission

List of Late Filers

Listed below are the names of filers from the Texas Ethics Commission who did not file reports or failed to pay penalty fines for late reports in reference to the listed filing deadline. If you have any questions, you may contact Robbie Douglas at (512) 463-5800.

Deadline: 8-Day Pre-election Report due October 29, 2012 for Candidates and Officeholders

Christopher D. Christal, P.O. Box 12104, San Antonio, Texas 78212

Joe Foster Jr., P.O. Box 611, Alpine, Texas 79831

Jesus A. "Alex" Mendoza, PMB 128, 2560 King Arthur Blvd., Ste. 124, Lewisville, Texas 75056

Alfred Molison Jr., P.O. Box 31546, Houston, Texas 77231

G. C. Molison, P.O. Box 31546, Houston, Texas 77231

Deadline: 8-Day Pre-election Report due October 29, 2012 for Committees

Christopher Plata, Houston Area Stonewall Democrats, 19514 Remington Cross, Houston, Texas, 77073

Deadline: Monthly Report due October 5, 2012 for Committees

Kevin Cox, Grand Prairie Police Association PAC, P.O. Box 531184, Grand Prairie, Texas 75053-1184

Deadline: Monthly Report due November 5, 2012 for Committees

Kevin Cox, Grand Prairie Police Association PAC, P.O. Box 531184, Grand Prairie, Texas 75053-1184

Deadline: Monthly Report due December 5, 2012 for Committees

Kevin Cox, Grand Prairie Police Association PAC, P.O. Box 531184, Grand Prairie, Texas 75053-1184

TRD-201300463
David Reisman
Executive Director
Texas Ethics Commission
Filed: February 5, 2013

♦ ♦ ♦

Texas Facilities Commission

Request for Proposals #303-4-20369

The Texas Facilities Commission (TFC), on behalf of the Texas Department of Insurance (TDI), the Health and Human Services Commission (HHSC), the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services (DARS), the State Office of Administrative Hearings (SOAH), and the Texas Lottery Commission (LOTTERY), announces the issuance of Request for Proposals (RFP) #303-4-20369. TFC seeks a five (5) or ten (10) year lease of approximately 24,359 square feet of office space in Fort Worth, Tarrant County, Texas.

The deadline for questions is February 25, 2013 and the deadline for proposals is March 4, 2013, at 3:00 p.m. The award date is April 17, 2013. TFC reserves the right to accept or reject any or all proposals submitted. TFC is under no legal or other obligation to execute a lease on the basis of this notice or the distribution of an RFP. Neither this notice nor the RFP commits TFC to pay for any costs incurred prior to the award of a grant.

Parties interested in submitting a proposal may obtain information by contacting the Regional Leasing Assistant, Evelyn Esquivel, at (512) 463-6494. A copy of the RFP may be downloaded from the Electronic State Business Daily at *http://esbd.cpa.state.tx.us/bid_show.cfm?bidid=104245.*

TRD-201300386
Kay Molina
General Counsel
Texas Facilities Commission
Filed: February 1, 2013

♦ ♦ ♦

Department of State Health Services

Notice of Request for Proposals for Zoonosis Control Animal Friendly Grants for the Spay/Neuter Project

INTRODUCTION

The Department of State Health Services (DSHS), Zoonosis Control Branch, announces a Request for Proposals (RFP) for the sterilization of dogs and cats owned by the public.

PURPOSE

DSHS, Zoonosis Control Branch, announces the expected availability of fiscal year 2014 state funds from the sale of "animal friendly" license plates to provide grants for the sterilization of dogs and cats owned by the public at no or minimal cost.

PERIOD OF PROJECT

It is expected that the contract will begin on or about August 31, 2013, and will be made for a 12-month budget period with a project period of two years.

AVAILABLE FUNDS

Approximately $200,000 is expected to be available to fund multiple contracts. One grant award per project period will be awarded per agency for the sterilization of dogs and/or cats. The specific dollar amount awarded to each applicant depends upon the merit and scope of the proposed project.

ELIGIBLE RESPONDENTS

Eligible respondents include: a private or public animal shelter (releasing agency); an organization that is qualified as a charitable organization under the Internal Revenue Code, §501(c)(3), and has animal welfare or sterilizing dogs and cats owned by the general public at minimal or no cost as its primary purpose; or a local nonprofit veterinary medical association--an organization set up by and comprised of several volunteer veterinarians in their immediate region for the purpose of presenting continuing education, planning group activities, or discussing issues common to their professional field, and has an established program for sterilizing dogs and cats owned by the general public at minimal or no cost. If a respondent is currently debarred, suspended, or otherwise excluded or ineligible for participation in federal or state assistance programs, the respondent is ineligible to apply for funds under this RFP.

SCHEDULE OF EVENTS

Issuance of the RFP: February 15, 2013

Application Deadline: April 16, 2013, 2:00 p.m. CDT

Award Notification on or about: June 12, 2013

Contract Start Date on or about: August 31, 2013

TO OBTAIN A COPY OF THE RFP

It is preferred that requests to obtain a copy of the RFP, scheduled for release on February 15, 2013, be downloaded from the Electronic State Business Daily (ESBD) website at http://esbd.cpa.state.tx.us. Those organizations without Internet access may obtain a copy of the RFP by contacting Charlotte Jackson, Client Services Contracting Unit, Mail Code 1886, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347, fax: (512) 776-7351, email: charlotte.jackson@dshs.state.tx.us.

CONTACT PERSON

All communications concerning the RFP shall be addressed in writing, by mail, by fax, or by email to Charlotte Jackson, Client Services Contracting Unit, Mail Code 1886, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347, fax: (512) 776-7351, or email: charlotte.jackson@dshs.state.tx.us.

TRD-201300378
Lisa Hernandez
General Counsel
Department of State Health Services
Filed: February 1, 2013

♦ ♦ ♦

Texas Department of Insurance

Company Licensing

Application to change the name of OAK BROOK COUNTY MUTUAL INSURANCE COMPANY to SAFEWAY COUNTY MUTUAL INSURANCE COMPANY a Domestic Fire and/or Casualty company. The home office is in Dallas, Texas.

Application to change the name of AMERICAN BUSINESS & PERSONAL INSURANCE MUTUAL, INC. to AMERICAN BUSINESS & MERCANTILE INSURANCE MUTUAL, INC. a Foreign Fire and/or Casualty company. The home office is in Wilmington, Delaware.

Application to do business in the State of Texas by CHILDREN'S MEDICAL CENTER HEALTH PLAN, a domestic Health Maintenance Organization. The home office is in Dallas, Texas.

Application to change the name of GREAT AMERICAN LIFE ASSURANCE COMPANY to ROCKLAND LIFE INSURANCE COMPANY - USA, assumed name in Texas of PRESIDENTAL LIFE INSURANCE COMPANY - USA a Foreign Life, Accident and/or Health company. The home office is in Wilmington, Delaware.

Any objections must be filed with the Texas Department of Insurance, within twenty (20) calendar days from the date of the *Texas Register* publication, addressed to the attention of Godwin Ohaechesi, 333 Guadalupe Street, MC 305-2C, Austin, Texas 78701.

TRD-201300368
Sara Waitt
General Counsel
Texas Department of Insurance
Filed: January 31, 2013

♦ ♦ ♦

Texas Lottery Commission

Instant Game Number 1457 "Kiss®"

1.0 Name and Style of Game.

A. The name of Instant Game No. 1457 is "KISS®". The play style is "key number match".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 1457 shall be $2.00 per Ticket.

1.2 Definitions in Instant Game No. 1457.

A. Display Printing - That area of the Instant Game Ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Ticket.

C. Play Symbol - The printed data under the latex on the front of the Instant Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except

for dual-image games. The possible black Play Symbols are: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, GUITAR SYMBOL, $2.00, $4.00, $5.00, $10.00, $20.00, $50.00, $100, $1,000, and $35,000.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 1457 - 1.2D

PLAY SYMBOL	CAPTION
1	ONE
2	TWO
3	THR
4	FOR
5	FIV
6	SIX
7	SVN
8	EGT
9	NIN
10	TEN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
GUITAR SYMBOL	DBL
$2.00	TWO$
$4.00	FOUR$
$5.00	FIVE$
$10.00	TEN$
$20.00	TWENTY
$50.00	FIFTY
$100	ONE HUND
$1,000	ONE THOU
$35,000	35 THOU

E. Serial Number - A unique 14 (fourteen) digit number appearing under the latex scratch-off covering on the front of the Ticket. There will be a four (4)-digit "security number" which will be individually boxed and randomly placed within the number. The remaining ten (10) digits of the Serial Number are the Validation Number. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 00000000000000.

F. Low-Tier Prize - A prize of $2.00, $4.00, $5.00, $10.00, or $20.00.

G. Mid-Tier Prize - A prize of $50.00 or $100.

H. High-Tier Prize - A prize of $1,000 or $35,000.

I. Bar Code - A 24 (twenty-four) character interleaved two (2) of five (5) Bar Code which will include a four (4) digit game ID, the seven (7) digit Pack number, the three (3) digit Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Ticket.

J. Pack-Ticket Number - A 14 (fourteen) digit number consisting of the four (4) digit game number (1457), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start with 001 and end with 125 within each Pack. The format will be: 1457-0000001-001.

K. Pack - A Pack of "KISS®" Instant Game Tickets contains 125 Tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). There will be 2 fanfold configurations for this game. Configuration A will show the front of Ticket 001 and the back of Ticket 125. Configuration B will show the back of Ticket 001 and the front of Ticket 125.

L. Non-Winning Ticket - A Ticket which is not programmed to be a winning Ticket or a Ticket that does not meet all of the requirements

of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401.

M. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "KISS®" Instant Game No. 1457 Ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general Ticket validation requirements set forth in Texas Lottery Rule, §401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each Instant Ticket. A prize winner in the "KISS®" Instant Game is determined once the latex on the Ticket is scratched off to expose 22 (twenty-two) Play Symbols. If a player matches any of YOUR NUMBERS Play Symbols to either of the WINNING NUMBERS Play Symbols, the player wins the prize for that number. If a player reveals a "GUITAR" Play Symbol, the player wins DOUBLE the prize for that symbol. No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game Ticket, all of the following requirements must be met:

1. Exactly 22 (twenty-two) Play Symbols must appear under the Latex Overprint on the front portion of the Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Ticket shall be intact;

6. The Serial Number, Retailer Validation Code, and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Ticket;

8. The Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted, or tampered with in any manner;

9. The Ticket must not be counterfeit in whole or in part;

10. The Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Ticket must not have been stolen, nor appear on any list of omitted Tickets or non-activated Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code, and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Ticket must be complete and not miscut, and have exactly 22 (twenty-two) Play Symbols under the Latex Overprint on the front portion of the Ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the Ticket;

14. The Serial Number of an apparent winning Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Tickets, and a Ticket with that Serial Number shall not have been paid previously;

15. The Ticket must not be blank or partially blank, misregistered, defective, or printed or produced in error;

16. Each of the 22 (twenty-two) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the 22 (twenty-two) Play Symbols on the Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Ticket. In the event a defective Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Ticket with another unplayed Ticket in that Instant Game (or a Ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Players can win up to ten (10) times on a Ticket in accordance with the approved prize structure.

B. Adjacent Non-Winning Tickets within a Pack will not have identical play and prize symbol patterns. Two (2) Tickets have identical play and prize symbol patterns if they have the same play and prize symbols in the same positions.

C. Each Ticket will have two (2) different "WINNING NUMBERS" Play Symbols.

D. Non-winning "YOUR NUMBERS" Play Symbols will all be different.

E. No Ticket will ever contain more than two (2) identical non-winning Prize Symbols.

F. The "GUITAR" Play Symbol will only appear as dictated by the prize structure.

G. Non-winning prize symbols will never be the same as the winning Prize Symbol(s).

H. The top prize symbol will appear on every Ticket unless otherwise restricted.

I. No prize amount in a non-winning spot will correspond with the "YOUR NUMBERS" Play Symbol (i.e., 5 and $5).

J. The "GUITAR" Play Symbol will never appear in the "WINNING NUMBERS" Play Symbol positions.

2.3 Procedure for Claiming Prizes.

A. To claim a "KISS®" Instant Game prize of $2.00, $4.00, $5.00, $10.00, $20.00, $50.00, or $100, a claimant shall sign the back of the Ticket in the space designated on the Ticket and present the winning Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identi-

fication, if appropriate, make payment of the amount due the claimant and physically void the Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $50.00 or $100 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "KISS®" Instant Game prize of $1,000 or $35,000, the claimant must sign the winning Ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "KISS®" Instant Game prize, the claimant must sign the winning Ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct:

1. a sufficient amount from the winnings of a prize winner who has been finally determined to be:

a. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

b. in default on a loan made under Chapter 52, Education Code; or

c. in default on a loan guaranteed under Chapter 57, Education Code; and

2. delinquent child support payments from the winnings of a prize winner in the amount of the delinquency as determined by a court or a Title IV-D agency under Chapter 231, Family Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

F. If a person is indebted or owes delinquent taxes to the State, and is selected as a winner in a promotional second-chance drawing, the debt to the State must be paid within 30 days of notification or the prize will be awarded to an Alternate.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the Ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize under $600 from the "KISS®" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of $600 or more from the "KISS®" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Tickets ordered. The number of actual prizes available in a game may vary based on number of Tickets manufactured, testing, distribution, sales, and number of prizes claimed. An Instant Game Ticket may continue to be sold even when all the top prizes have been claimed.

2.9 Promotional Second-Chance Drawings. Any non-winning "KISS®" Instant Game scratch-off Ticket may be entered into one of four promotional drawings for a chance to win a promotional second-chance drawing prize. See instructions on the back of the Ticket for information on eligibility and entry requirements.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game Ticket in the space designated, a Ticket shall be owned by the physical possessor of said Ticket. When a signature is placed on the back of the Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Ticket in the space designated. If more than one name appears on the back of the Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game Tickets and shall not be required to pay on a lost or stolen Instant Game Ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 8,160,000 Tickets in the Instant Game No. 1457. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 1457 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$2	783,360	10.42
$4	848,640	9.62
$5	130,560	62.50
$10	97,920	83.33
$20	65,280	125.00
$50	25,602	318.73
$100	2,890	2,823.53
$1,000	102	80,000.00
$35,000	8	1,020,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 4.18. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of Tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 1457 without advance notice, at which point no further Tickets in that game may be sold. The determination of the closing date and reasons for closing will be made in accordance with the Instant Game closing procedures and the Instant Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing an Instant Game Ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 1457, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401, and all final decisions of the Executive Director.

TRD-201300365
Bob Biard
General Counsel
Texas Lottery Commission
Filed: January 31, 2013

♦ ♦ ♦

Instant Game Number 1499 "Fabulous 5's"

1.0 Name and Style of Game.

A. The name of Instant Game No. 1499 is "FABULOUS 5'S". The play style is "match 3 of X".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 1499 shall be $1.00 per Ticket.

1.2 Definitions in Instant Game No. 1499.

A. Display Printing - That area of the instant game Ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Ticket.

C. Play Symbol - The printed data under the latex on the front of the instant Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: 5 SYMBOL, $1.00, $2.00, $5.00, $10.00, $15.00, $20.00, $50.00, $500 and $1,000.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 1499 - 1.2D

PLAY SYMBOL	CAPTION
5 SYMBOL	WIN$
$1.00	ONE$
$2.00	TWO$
$5.00	FIVE$
$10.00	TEN$
$15.00	FIFTN
$20.00	TWENTY
$50.00	FIFTY
$500	FIV HUN
$1,000	ONE THOU

E. Serial Number - A unique 14 (fourteen) digit number appearing under the latex scratch-off covering on the front of the Ticket. There will be a four (4)-digit "security number" which will be individually boxed and randomly placed within the number. The remaining ten (10) digits of the Serial Number are the Validation Number. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 00000000000000.

F. Low-Tier Prize - A prize of $1.00, $2.00, $5.00, $10.00, $15.00 or $20.00.

G. Mid-Tier Prize - A prize of $50.00 or $500.

H. High-Tier Prize - A prize of $1,000.

I. Bar Code - A 24 (twenty-four) character interleaved two (2) of five (5) Bar Code which will include a four (4) digit game ID, the seven (7) digit Pack number, the three (3) digit Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Ticket.

J. Pack-Ticket Number - A 14 (fourteen) digit number consisting of the four (4) digit game number (1499), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start with 001 and end with 150 within each Pack. The format will be: 1499-0000001-001.

K. Pack - A pack of "FABULOUS 5'S" Instant Game Tickets contain 150 Tickets, packed in plastic shrink-wrapping and fanfolded in pages of five (5). Ticket 001 to 005 will be on the top page; Tickets 006 to 010 on the next page etc.; and Tickets 146 to 150 will be on the last page. All packs will be tightly shrink-wrapped. There will be no breaks between the tickets in a Pack.

L. Non-Winning Ticket - A Ticket which is not programmed to be a winning Ticket or a Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401.

M. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "FABULOUS 5'S" Instant Game No. 1499 Ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general Ticket validation requirements set forth in Texas Lottery Rule, §401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant Ticket. A prize winner in the "FABULOUS 5'S" Instant Game is determined once the latex on the Ticket is scratched off to expose 6 (six) Play Symbols. If a player reveals 3 matching prize amounts Play Symbols, the player wins that prize. If a player reveals a "5" Play Symbol in the play area, the player wins the corresponding prize in the PRIZE LEGEND (only highest prize paid). No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game Ticket, all of the following requirements must be met:

1. Exactly 6 (six) Play Symbols must appear under the Latex Overprint on the front portion of the Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Ticket;

8. The Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Ticket must not be counterfeit in whole or in part;

10. The Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Ticket must not have been stolen, nor appear on any list of omitted Tickets or non-activated Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Ticket must be complete and not miscut, and have exactly 6 (six) Play Symbols under the Latex Overprint on the front portion of

the Ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the Ticket;

14. The Serial Number of an apparent winning Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Tickets, and a Ticket with that Serial Number shall not have been paid previously;

15. The Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 6 (six) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the 6 (six) Play Symbols on the Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Ticket. In the event a defective Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Ticket with another unplayed Ticket in that Instant Game (or a Ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive Non-Winning Tickets within a Pack will not have identical patterns of either Play Symbols or Prize Symbols.

B. A Ticket will win as indicated by the prize structure.

C. A Ticket can win up to one (1) time.

D. No Ticket will contain two (2) sets of three identical Prize Symbols.

E. No Ticket will contain four (4) or more identical Prize Symbols.

F. No Ticket will contain more than four (4) "5" Play Symbols.

G. No Ticket will contain one (1) or more "5" Play Symbols and three (3) identical Prize Symbols.

H. The "5" Play Symbol will only appear on intended winning Tickets as dictated by the prize structure.

I. A $5 Prize Symbol will never appear on a Ticket containing one (1) or more "5" Play Symbols.

2.3 Procedure for Claiming Prizes.

A. To claim a "FABULOUS 5'S" Instant Game prize of $1.00, $2.00, $5.00, $10.00, $15.00, $20.00, $50.00 or $500, a claimant shall sign the back of the Ticket in the space designated on the Ticket and present the winning Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $50.00 or $500 Ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "FABULOUS 5'S" Instant Game prize of $1,000, the claimant must sign the winning Ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "FABULOUS 5'S" Instant Game prize, the claimant must sign the winning Ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct:

1. A sufficient amount from the winnings of a prize winner who has been finally determined to be:

a. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

b. in default on a loan made under Chapter 52, Education Code; or

c. in default on a loan guaranteed under Chapter 57, Education Code; and

2. delinquent child support payments from the winnings of a prize winner in the amount of the delinquency as determined by a court or a Title IV-D agency under Chapter 231, Family Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the Ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize under $600 from the "FABULOUS 5'S" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of $600 or more from the "FABULOUS 5'S" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code Section 466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Tickets ordered. The number of actual prizes available in a game may vary based on number of Tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game Ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game Ticket in the space designated, a Ticket shall be owned by the physical possessor of said Ticket. When a signature is placed on the back of the Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Ticket in the space designated. If more than one name appears on the back of the Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game Tickets and shall not be required to pay on a lost or stolen Instant Game Ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 11,160,000 Tickets in the Instant Game No. 1499. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 1499 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$1	1,252,400	8.91
$2	533,200	20.93
$5	334,800	33.33
$10	86,800	128.57
$15	49,600	225.00
$20	24,800	450.00
$50	5,084	2,195.12
$500	310	36,000.00
$1,000	186	60,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 4.88. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of Tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 1499 without advance notice, at which point no further Tickets in that game may be sold. The determination of the closing date and reasons for closing will be made in accordance with the instant Game closing procedures and the Instant Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing an Instant Game Ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 1499, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401, and all final decisions of the Executive Director.

TRD-201300464
Bob Biard
General Counsel
Texas Lottery Commission
Filed: February 5, 2013

♦ ♦ ♦

Instant Game Number 1500 "Sizzlin' 7's"

1.0 Name and Style of Game.

A. The name of Instant Game No. 1500 is "SIZZLIN' 7'S". The play style is "key symbol match".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 1500 shall be $5.00 per Ticket.

1.2 Definitions in Instant Game No. 1500.

A. Display Printing - That area of the instant game Ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Ticket.

C. Play Symbol - The printed data under the latex on the front of the instant Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: $5.00, $10.00, $15.00, $20.00, $50.00, $100, $250, $500, $1,000, $70,000, 7 SYMBOL, MONEY BAG SYMBOL, ROLL OF MONEY SYMBOL, BELL SYMBOL, CLOVER SYMBOL, LEMON SYMBOL, MONEY CLIP SYMBOL, RAINBOW SYMBOL, GOLD BAR SYMBOL, TREASURE CHEST SYMBOL, COIN SYMBOL, STACK OF CASH SYMBOL, PIGGY BANK SYMBOL, SAFE SYMBOL, CHERRY SYMBOL, WALLET SYMBOL, STAR SYMBOL, WISHBONE SYMBOL, BANANA SYMBOL and SUN SYMBOL.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 1500 - 1.2D

PLAY SYMBOL	CAPTION
$5.00	FIVE$
$10.00	TEN$
$15.00	FIFTN
$20.00	TWENTY
$50.00	FIFTY
$100	ONE HUND
$250	TWO FTY
$500	FIV HUN
$1,000	ONE THOU
$70,000	70 THOU
7 SYMBOL	WIN
MONEY BAG SYMBOL	DOUBLE
ROLL OF MONEY SYMBOL	TRIPLE
BELL SYMBOL	BELL
CLOVER SYMBOL	CLOVER
LEMON SYMBOL	LEMON
MONEY CLIP SYMBOL	CLIP
RAINBOW SYMBOL	RAINBW
GOLD BAR SYMBOL	GOLD
TREASURE CHEST SYMBOL	CHEST
COIN SYMBOL	COIN
STACK OF CASH SYMBOL	CASH
PIGGY BANK SYMBOL	PGYBNK
SAFE SYMBOL	SAFE
CHERRY SYMBOL	CHERRY
WALLET SYMBOL	WALLET
STAR SYMBOL	STAR
WISHBONE SYMBOL	WSHBNE
BANANA SYMBOL	BANANA
SUN SYMBOL	SUN

E. Serial Number - A unique 14 (fourteen) digit number appearing under the latex scratch-off covering on the front of the Ticket. There will be a four (4)-digit "security number" which will be individually boxed and randomly placed within the number. The remaining ten (10) digits of the Serial Number are the Validation Number. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 00000000000000.

F. Low-Tier Prize - A prize of $5.00, $10.00, $15.00 or $20.00.

G. Mid-Tier Prize - A prize of $50.00, $100, $250 or $500.

H. High-Tier Prize - A prize of $1,000 or $70,000.

I. Bar Code - A 24 (twenty-four) character interleaved two (2) of five (5) Bar Code which will include a four (4) digit game ID, the seven (7) digit Pack number, the three (3) digit Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Ticket.

J. Pack-Ticket Number - A 14 (fourteen) digit number consisting of the four (4) digit game number (1500), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start with 001 and end with 075 within each Pack. The format will be: 1500-0000001-001.

K. Pack - A Pack of "SIZZLIN' 7'S" Instant Game Tickets contains 075 Tickets, Packed in plastic shrink-wrapping and fanfolded in pages of one (1). Ticket 001 will be shown on the front of the Pack; the back of Ticket 075 will be revealed on the back of the Pack. All Packs will be tightly shrink-wrapped. There will be no breaks between the Tickets in a Pack. Every other book will reverse i.e., reverse order will be: the back of Ticket 001 will be shown on the front of the Pack and the front of Ticket 075 will be shown on the back of the Pack.

L. Non-Winning Ticket - A Ticket which is not programmed to be a winning Ticket or a Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401.

M. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "SIZZLIN' 7'S" Instant Game No. 1500 Ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general Ticket validation requirements set forth in Texas Lottery Rule, §401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant Ticket. A prize winner in the "SIZZLIN' 7'S" Instant Game is determined once the latex on the Ticket is scratched off to expose 34 (thirty-four) Play Symbols. If a player reveals a "7" Play Symbol, the player wins the PRIZE for that symbol. If a player reveals a "Money Bag" Play Symbol, the player wins DOUBLE the PRIZE for that symbol. If a player reveals a "Roll Of Money" Play Symbol, the player wins TRIPLE the PRIZE for that symbol. No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game Ticket, all of the following requirements must be met:

1. Exactly 34 (thirty-four) Play Symbols must appear under the Latex Overprint on the front portion of the Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Ticket;

8. The Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Ticket must not be counterfeit in whole or in part;

10. The Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Ticket must not have been stolen, nor appear on any list of omitted Tickets or non-activated Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Ticket must be complete and not miscut, and have exactly 34 (thirty-four) Play Symbols under the Latex Overprint on the front portion of the Ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the Ticket;

14. The Serial Number of an apparent winning Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Tickets, and a Ticket with that Serial Number shall not have been paid previously;

15. The Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 34 (thirty-four) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the 34 (thirty-four) Play Symbols on the Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Ticket. In the event a defective Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Ticket with another unplayed Ticket in that Instant Game (or a Ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive Non-Winning Tickets within a Pack will not have identical patterns of either Play Symbols or Prize Symbols.

B. A Ticket will win as indicated by the prize structure.

C. A Ticket can win up to seventeen (17) times.

D. On winning and Non-Winning Tickets, the top cash prizes of $70,000 and $1,000 will each appear at least once, except on Tickets winning seventeen (17) times.

E. On winning Tickets, a non-winning prize amount will not match a winning prize amount.

F. On all Tickets, a prize amount will not appear more than 3 times, except as required by the prize structure to create multiple wins.

G. This Ticket consists of seventeen (17) Play Symbols and seventeen (17) Prize Symbols.

H. Play Symbols will not appear more than once on any one Ticket, except where required by a multiple win.

I. The "7" Play Symbol will only appear with the caption WIN and will only appear according to the prize structure.

J. The "Money Bag" Play Symbol will only appear with the caption DOUBLE and will only appear according to the prize structure.

K. The "Roll of Money" Play Symbol will only appear with the caption TRIPLE and will only appear according to the prize structure.

L. The "7", "Money Bag" and "Roll of Money" Play Symbols will not appear on a Non-Winning Ticket.

2.3 Procedure for Claiming Prizes.

A. To claim a "SIZZLIN' 7'S" Instant Game prize of $5.00, $10.00, $15.00, $20.00, $50.00, $100, $250 or $500, a claimant shall sign the back of the Ticket in the space designated on the Ticket and present the winning Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $50.00, $100, $250 or $500 Ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "SIZZLIN' 7'S" Instant Game prize of $1,000 or $70,000, the claimant must sign the winning Ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "SIZZLIN' 7'S" Instant Game prize, the claimant must sign the winning Ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct:

1. A sufficient amount from the winnings of a prize winner who has been finally determined to be:

a. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

b. in default on a loan made under Chapter 52, Education Code; or

c. in default on a loan guaranteed under Chapter 57, Education Code; and

2. delinquent child support payments from the winnings of a prize winner in the amount of the delinquency as determined by a court or a Title IV-D agency under Chapter 231, Family Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the Ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize under $600 from the "SIZZLIN' 7'S" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of $600 or more from the "SIZZLIN' 7'S" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code Section 466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Tickets ordered. The number of actual prizes available in a game may vary based on number of Tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game Ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game Ticket in the space designated, a Ticket shall be owned by the physical possessor of said Ticket. When a signature is placed on the back of the Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Ticket in the space designated. If more than one name appears on the back of the Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game Tickets and shall not be required to pay on a lost or stolen Instant Game Ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 8,280,000 Tickets in the Instant Game No. 1500. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 1500 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$5	1,085,600	7.63
$10	552,000	15.00
$15	202,400	40.91
$20	184,000	45.00
$50	85,031	97.38
$100	30,912	267.86
$250	3,335	2,482.76
$500	2,714	3,050.85
$1,000	115	72,000.00
$70,000	12	690,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 3.86. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of Tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 1500 without advance notice, at which point no further Tickets in that game may be sold. The determination of the closing date and reasons for closing will be made in accordance with the Instant Game closing procedures and the Instant Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing an Instant Game Ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 1500, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401, and all final decisions of the Executive Director.

TRD-201300465
Bob Biard
General Counsel
Texas Lottery Commission
Filed: February 5, 2013

♦ ♦ ♦

Instant Game Number 1501 "Money Multiplier"

1.0 Name and Style of Game.

A. The name of Instant Game No. 1501 is "MONEY MULTIPLIER". The play style is "key number match".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 1501 shall be $2.00 per Ticket.

1.2 Definitions in Instant Game No. 1501.

A. Display Printing - That area of the instant game Ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Ticket.

C. Play Symbol - The printed data under the latex on the front of the Instant Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, MONEY BAG SYMBOL, $2.00, $4.00, $5.00, $6.00, $10.00, $20.00, $40.00, $100, $500, and $20,000.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink

in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO.1501 - 1.2D

PLAY SYMBOL	CAPTION
1	ONE
2	TWO
3	THR
4	FOR
5	FIV
6	SIX
7	SVN
8	EGT
9	NIN
10	TEN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
17	SVT
18	ETN
19	NTN
20	TWY
21	TWON
22	TWTO
23	TWTH
24	TWFR
25	TWFV
MONEY BAG SYMBOL	DBL
$2.00	TWO$
$4.00	FOUR$
$5.00	FIVE$
$6.00	SIX$
$10.00	TEN$
$20.00	TWENTY
$40.00	FORTY
$100	ONE HUND
$500	FIV HUND
$20,000	20 THOU

E. Serial Number - A unique 14 (fourteen) digit number appearing under the latex scratch-off covering on the front of the Ticket. There will be a four (4)-digit "security number" which will be individually boxed and randomly placed within the number. The remaining ten (10) digits of the Serial Number are the Validation Number. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 00000000000000.

F. Low-Tier Prize - A prize of $2.00, $4.00, $5.00, $6.00, $10.00, or $20.00.

G. Mid-Tier Prize - A prize of $40.00, $100, or $500.

H. High-Tier Prize - A prize of $20,000.

I. Bar Code - A 24 (twenty-four) character interleaved two (2) of five (5) Bar Code which will include a four (4) digit game ID, the seven (7) digit Pack number, the three (3) digit Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Ticket.

J. Pack-Ticket Number - A 14 (fourteen) digit number consisting of the four (4) digit game number (1501), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start with 001 and end with 125 within each Pack. The format will be: 1501-0000001-001.

K. Pack - A pack of "MONEY MULTIPLIER" Instant Game Tickets contains 125 Tickets, packed in plastic shrink-wrapping and fanfolded in pages of two (2). One Ticket will be folded over to expose a front and back of one Ticket on each pack. Please note the books will be in an A, B, C and D configuration.

L. Non-Winning Ticket - A Ticket which is not programmed to be a winning Ticket or a Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401.

M. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "MONEY MULTIPLIER" Instant Game No. 1501 Ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general Ticket validation requirements set forth in Texas Lottery Rule, §401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each Instant Ticket. A prize winner in the "MONEY MULTIPLIER" Instant Game is determined once the latex on the Ticket is scratched off to expose 21 (twenty-one) Play Symbols. Each time a player reveals a YOUR LUCKY NUMBER Play Symbol within a GAME, the player wins the PRIZE for that GAME. If a player reveals a "MONEY BAG" Play Symbol, the player wins DOUBLE the prize for that symbol. No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game Ticket, all of the following requirements must be met:

1. Exactly 21 (twenty-one) Play Symbols must appear under the Latex Overprint on the front portion of the Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Ticket;

8. The Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Ticket must not be counterfeit in whole or in part;

10. The Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Ticket must not have been stolen, nor appear on any list of omitted Tickets or non-activated Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Ticket must be complete and not miscut, and have exactly 21 (twenty-one) Play Symbols under the Latex Overprint on the front portion of the Ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the Ticket;

14. The Serial Number of an apparent winning Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Tickets, and a Ticket with that Serial Number shall not have been paid previously;

15. The Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 21 (twenty-one) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the 21 (twenty-one) Play Symbols on the Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Ticket. In the event a defective Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Ticket with another unplayed Ticket in that Instant Game (or a Ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Players can win up to fifteen (15) times on a Ticket in accordance with the approved prize structure.

B. Adjacent Non-Winning Tickets within a book will not have identical patterns. Two (2) Tickets have identical patterns if they have the same symbols in the same positions.

C. There will be a random distribution of all symbols on the Ticket unless affected by other constraints, play action or prize structure.

D. There will be no more than two (2) identical non-winning Prize Symbols on a Ticket.

E. The non-winning "YOUR NUMBERS" Play Symbols will all be different.

F. No adjacent Tickets within a book will have identical "YOUR LUCKY NUMBER" Play Symbols.

G. The "MONEY BAG" Play Symbol will only appear on winning Tickets, winning double as dictated by the prize structure.

H. The "MONEY BAG" Play Symbol will never appear in the "YOUR LUCKY NUMBER" play spot.

I. Prizes for winning games will not match prizes for non-winning games.

J. The top Prize Symbol will appear on every Ticket unless otherwise restricted.

K. No prize amount will correspond with any number in a non-winning spot in the corresponding GAME.

2.3 Procedure for Claiming Prizes.

A. To claim a "MONEY MULTIPLIER" Instant Game prize of $2.00, $4.00, $5.00, $6.00, $10.00, $20.00, $40.00, $100, or $500, a claimant shall sign the back of the Ticket in the space designated on the Ticket and present the winning Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $40.00, $100, or $500 Ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "MONEY MULTIPLIER" Instant Game prize of $20,000, the claimant must sign the winning Ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "MONEY MULTIPLIER" Instant Game prize, the claimant must sign the winning Ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct:

1. A sufficient amount from the winnings of a prize winner who has been finally determined to be:

a. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

b. in default on a loan made under Chapter 52, Education Code; or

c. in default on a loan guaranteed under Chapter 57, Education Code; and

2. delinquent child support payments from the winnings of a prize winner in the amount of the delinquency as determined by a court or a Title IV-D agency under Chapter 231, Family Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the Ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize under $600 from the "MONEY MULTIPLIER" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of $600 or more from the "MONEY MULTIPLIER" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Tickets ordered. The number of actual prizes available in a game may vary based on number of Tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game Ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game Ticket in the space designated, a Ticket shall be owned by the physical possessor of said Ticket. When a signature is placed on the back of the Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Ticket in the space designated. If more than one name appears on the back of the Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game Tickets and shall not be required to pay on a lost or stolen Instant Game Ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 6,000,000 Tickets in the Instant Game No. 1501. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 1501 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$2	672,000	8.93
$4	408,000	14.71
$5	144,000	41.67
$6	96,000	62.50
$10	96,000	62.50
$20	72,000	83.33
$40	20,500	292.68
$100	1,250	4,800.00
$500	125	48,000.00
$20,000	6	1,000,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 3.97. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of Tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 1501 without advance notice, at which point no further Tickets in that game may be sold. The determination of the closing date and reasons for closing will be made in accordance with the Instant Game closing procedures and the Instant Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing an Instant Game Ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 1501, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401, and all final decisions of the Executive Director.

TRD-201300377
Bob Biard
General Counsel
Texas Lottery Commission
Filed: February 1, 2013

♦ ♦ ♦

Instant Game Number 1502 "Cash Cow"

1.0 Name and Style of Game.

A. The name of Instant Game No. 1502 is "CASH COW". The play style is "match 3 of X".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 1502 shall be $1.00 per Ticket.

1.2 Definitions in Instant Game No. 1502.

A. Display Printing - That area of the Instant Game Ticket outside of the area where the overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Ticket.

C. Play Symbol - The printed data under the latex on the front of the Instant Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: MILK BOTTLE SYMBOL, COWBELL SYMBOL, SUN SYMBOL, HAY SYMBOL, TRACTOR SYMBOL, $1.00, $2.00, $4.00, $5.00, $10.00, $20.00, $50.00, $100, $200, and $1,000.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 1502 - 1.2D

PLAY SYMBOL	CAPTION
MILK BOTTLE SYMBOL	MILKBOTTLE
COWBELL SYMBOL	COWBELL
SUN SYMBOL	SUN
HAY SYMBOL	HAY
TRACTOR SYMBOL	TRACTOR
$1.00	ONE$
$2.00	TWO$
$4.00	FOUR$
$5.00	FIVE$
$10.00	TEN$
$20.00	TWENTY
$50.00	FIFTY
$100	ONE HUND
$200	TWO HUND
$1,000	ONE THOU

E. Serial Number - A unique 14 (fourteen) digit number appearing under the latex scratch-off covering on the front of the Ticket. There will be a four (4)-digit "security number" which will be individually boxed and randomly placed within the number. The remaining ten (10) digits of the Serial Number are the Validation Number. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 00000000000000.

F. Low-Tier-Prize - A prize of $1.00, $2.00, $4.00, $5.00, $10.00, $15.00, or $20.00.

G. Mid-Tier-Prize - A prize of $50.00, $60.00, $100, or $200.

H. High-Tier-Prize - A prize of $1,000.

I. Bar Code - A 24 (twenty-four) character interleaved two (2) of five (5) Bar Code which will include a four (4) digit game ID, the seven (7) digit Pack number, the three (3) digit Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Ticket.

J. Pack-Ticket Number - A 14 (fourteen) digit number consisting of the four (4) digit game number (1502), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start with 001 and end with 150 within each Pack. The format will be: 1502-0000001-001.

K. Pack - A Pack of "CASH COW" Instant Game Tickets contains 150 Tickets, packed in plastic shrink-wrapping and fanfolded in pages of five (5). Tickets 001 to 005 will be on the top page; Tickets 006 to 010 on the next page; etc.; and Tickets 146 to 150 will be on the last page with backs exposed. Ticket 001 will be folded over so the front of Ticket 001 and 010 will be exposed.

L. Non-Winning Ticket - A Ticket which is not programmed to be a winning Ticket or a Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401.

M. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "CASH COW" Instant Game No. 1502 Ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general Ticket validation requirements set forth in Texas Lottery Rule, §401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each Instant Ticket. A prize winner in the "CASH COW" Instant Game is determined once the latex on the Ticket is scratched off to expose 11 (eleven) Play Symbols. If a player matches 3 Play Symbol amounts, the player wins that amount. If a player reveals 2 matching Play Symbols under the cow's sunglasses, the player wins $10 instantly! No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game Ticket, all of the following requirements must be met:

1. Exactly 11 (eleven) Play Symbols must appear under the Latex Overprint on the front portion of the Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Ticket shall be intact;

6. The Serial Number, Retailer Validation Code, and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Ticket;

8. The Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted, or tampered with in any manner;

9. The Ticket must not be counterfeit in whole or in part;

10. The Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Ticket must not have been stolen, nor appear on any list of omitted Tickets or non-activated Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code, and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Ticket must be complete and not miscut, and have exactly 11 (eleven) Play Symbols under the Latex Overprint on the front portion of the Ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the Ticket;

14. The Serial Number of an apparent winning Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Tickets, and a Ticket with that Serial Number shall not have been paid previously;

15. The Ticket must not be blank or partially blank, misregistered, defective, or printed or produced in error;

16. Each of the 11 (eleven) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the 11 (eleven) Play Symbols on the Ticket must be printed in the symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Ticket Serial Numbers must be printed in the serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Ticket. In the event a defective Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Ticket with another unplayed Ticket in that Instant Game (or a Ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Players can win up to two (2) times on a Ticket in accordance with the approved prize structure.

B. Adjacent Non-Winning Tickets within a Pack will not have identical Play and Prize Symbol patterns. Two (2) Tickets have identical Play and Prize Symbol patterns if they have the same symbols in the same positions.

C. The top prize will appear on every Ticket unless otherwise restricted.

D. MATCH 3 GAME PLAY AREA: There will never be more than 3 matching Prize Symbols.

E. MATCH 3 GAME PLAY AREA: There will never be more than 1 set of 3 matching Prize Symbols. (i.e., three $10 symbols and three $20 symbols).

F. MATCH 3 GAME PLAY AREA: No Ticket will contain more than 3 pair of matching Prize Symbols.

G. SUNGLASSES PLAY AREA: When two matching Play Symbols are revealed, the associated prize will always be $10 as dictated by the prize structure.

2.3 Procedure for Claiming Prizes.

A. To claim a "CASH COW" Instant Game prize of $1.00, $2.00, $4.00, $5.00, $10.00, $15.00, $20.00, $50.00, $60.00, $100, or $200, a claimant shall sign the back of the Ticket in the space designated on the Ticket and present the winning Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $50.00, $60.00, $100, or $200 Ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "CASH COW" Instant Game prize of $1,000, the claimant must sign the winning Ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "CASH COW" Instant Game prize, the claimant must sign the winning Ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct:

1. A sufficient amount from the winnings of a prize winner who has been finally determined to be:

a. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

b. in default on a loan made under Chapter 52, Education Code; or

c. in default on a loan guaranteed under Chapter 57, Education Code; and

2. delinquent child support payments from the winnings of a prize winner in the amount of the delinquency as determined by a court or a Title IV-D agency under Chapter 231, Family Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the Ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize under $600 from the "CASH COW" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of $600 or more from the "CASH COW" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Tickets ordered. The number of actual prizes available in a game may vary based on number of Tickets manufactured, testing, distribution, sales, and number of prizes claimed. An Instant Game Ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game Ticket in the space designated, a Ticket shall be owned by the physical possessor of said Ticket. When a signature is placed on the back of the Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Ticket in the space designated. If more than one name appears on the back of the Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game Tickets and shall not be required to pay on a lost or stolen Instant Game Ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 10,080,000 Tickets in the Instant Game No. 1502. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 1502 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$1	1,008,000	10.00
$2	806,400	12.50
$4	134,400	75.00
$5	67,200	150.00
$10	67,200	150.00
$15	67,200	150.00
$20	33,600	300.00
$50	420	24,000.00
$60	1,470	6,857.14
$100	336	30,000.00
$200	84	120,000.00
$1,000	42	240,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 4.61. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of Tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 1502 without advance notice, at which point no further Tickets in that game may be sold. The determination of the closing date and reasons for closing will be made in accordance with the Instant Game closing procedures and the Instant Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing an Instant Game Ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 1502, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401, and all final decisions of the Executive Director.

TRD-201300366
Bob Biard
General Counsel
Texas Lottery Commission
Filed: January 31, 2013

♦ ♦ ♦

Texas Low-Level Radioactive Waste Disposal Compact Commission

Notice of Receipt of Application for Importation of Waste and Import Agreement

Please take notice that, pursuant to Texas Low-Level Radioactive Waste Disposal Compact Commission rule 31 TAC §675.23, the Compact Commission has received an application for and a proposed agreement for import for disposal of low-level radioactive waste from:

American Airlines, Inc. (TLLRWDCC #1-0026-00)

4100 North Mingo Road

Tulsa, OK 74116

P.O. Box 582809, Mail Drop 508

Tulsa, OK 74158-2809

The application is being placed on the Compact Commission web site, www.tllrwdcc.org, where it will be available for inspection and copying.

Comments on the application are due to be received by February 27, 2013. Comments should be mailed to:

Texas Low-Level Radioactive Waste Disposal Compact Commission

333 Guadalupe Street, #3-240

Austin, Texas 78701

Comments may also be submitted via email to: administration@tllrwdcc.org.

TRD-201300382
Audrey Ferrell
Administrator
Texas Low-Level Radioactive Waste Disposal Compact Commission
Filed: February 1, 2013

♦ ♦ ♦

Notice of Receipt of Application for Importation of Waste and Import Agreement

Please take notice that, pursuant to Texas Low-Level Radioactive Waste Disposal Compact Commission rule 31 TAC §675.23, the Compact Commission has received an application for and a proposed agreement for import for disposal of low-level radioactive waste from:

Duke Energy (TLLRWDCC #1-0027-00)

Highway 87 North

Southport, NC 28461

The application is being placed on the Compact Commission web site, www.tllrwdcc.org, where it will be available for inspection and copying.

Comments on the application are due to be received by February 27, 2013. Comments should be mailed to:

Texas Low-Level Radioactive Waste Disposal Compact Commission

333 Guadalupe Street, #3-240

Austin, Texas 78701

Comments may also be submitted via email to: administration@tllrwdcc.org.

TRD-201300383
Audrey Ferrell
Administrator
Texas Low-Level Radioactive Waste Disposal Compact Commission
Filed: February 1, 2013

♦ ♦ ♦

Notice of Receipt of Application for Importation of Waste and Import Agreement

Please take notice that, pursuant to Texas Low-Level Radioactive Waste Disposal Compact Commission rule 31 TAC §675.23, the Compact Commission has received an application for and a proposed agreement for import for disposal of low-level radioactive waste from:

PG&E (TLLRWDCC #1-0028-00)

1000 King Salmon Ave.

Eureka, CA 95503

The application is being placed on the Compact Commission web site, www.tllrwdcc.org, where it will be available for inspection and copying.

Comments on the application are due to be received by February 27, 2013. Comments should be mailed to:

Texas Low-Level Radioactive Waste Disposal Compact Commission

333 Guadalupe Street, #3-240

Austin, Texas 78701

Comments may also be submitted via email to: administration@tllrwdcc.org.

TRD-201300384
Audrey Ferrell
Administrator
Texas Low-Level Radioactive Waste Disposal Compact Commission
Filed: February 1, 2013

♦ ♦ ♦

Notice of Receipt of Application for Importation of Waste and Import Agreement

Please take notice that, pursuant to Texas Low-Level Radioactive Waste Disposal Compact Commission rule 31 TAC §675.23, the Compact Commission has received an application for and a proposed agreement for import for disposal of low-level radioactive waste from:

RAM Services (TLLRWDCC #1-0029-00)

510 County Highway V

Two Rivers, WI 54241

The application is being placed on the Compact Commission web site, www.tllrwdcc.org, where it will be available for inspection and copying.

Comments on the application are due to be received by February 27, 2013. Comments should be mailed to:

Texas Low-Level Radioactive Waste Disposal Compact Commission

333 Guadalupe Street, #3-240

Austin, Texas 78701

Comments may also be submitted via email to: administration@tllrwdcc.org.

TRD-201300385
Audrey Ferrell
Administrator
Texas Low-Level Radioactive Waste Disposal Compact Commission
Filed: February 1, 2013

♦ ♦ ♦

North Central Texas Council of Governments

Cotton Belt Joint Procurement Guidelines Release

The North Central Texas Council of Governments (NCTCOG), acting as the Responsible Governmental Entity under Chapter 2267 of the Texas Government Code on behalf of certain cities along the Cotton Belt Corridor, and Dallas Area Rapid Transit and the Fort Worth Transportation Authority acting under Chapter 452 of the Texas Transportation Code have adopted Joint Procurement Guidelines for Development of the Cotton Belt Corridor. The Guidelines are intended to encourage and facilitate private sector participation in the design, construction, operation, and maintenance of passenger rail services in the Cotton Belt Corridor, a certain 62 mile railroad right-of-way stretching from southwest Fort Worth to Plano.

Interested persons are directed to www.nctcog.org or www.dart.org for additional information. A hardcopy of the Guidelines is available for review during regular business hours at NCTCOG located at 616 Six Flags Drive, Centerpoint Two, Arlington, Texas 76011.

TRD-201300479
R. Michael Eastland
Executive Director
North Central Texas Council of Governments
Filed: February 6, 2013

♦ ♦ ♦

Notice of Consultant Contract Award

Pursuant to the provisions of Government Code, Chapter 2254, the North Central Texas Council of Governments publishes this notice of consultant contract award. The consultant request appeared in the September 28, 2012, issue of the *Texas Register* (37 TexReg 7806). The selected consultant will perform technical and professional work for the North Central Texas Activity-Based Model Framework.

The consultant selected for this project is Parsons Brinckerhoff, Inc., 2777 Stemmons Freeway, Suite 1600, Dallas, Texas 75207. The amount of the contract is not to exceed $150,000.

TRD-201300369
R. Michael Eastland
Executive Director
North Central Texas Council of Governments
Filed: January 31, 2013

♦ ♦ ♦

Public Utility Commission of Texas

Notice of Application for Designation as a Resale Eligible Telecommunications Provider

Notice is given to the public of an application filed with the Public Utility Commission of Texas (commission) on January 29, 2013, for designation as a resale eligible telecommunications provider (R-ETP) pursuant to P.U.C. Substantive Rule §26.419.

Docket Title and Number: Application of Everybody's Phone Company for Designation as a Resale Eligible Telecommunications Provider Pursuant to P.U.C. Substantive Rule §26.419. Docket Number 41173.

The Application: The company is requesting R-ETP designation in order to be eligible to receive funds from the Texas Universal Service Fund (TUSF) for reimbursement of the discounts provided through the Lifeline Program. Everybody's Phone Company seeks R-ETP designation that will cover all of the wire centers of Southwestern Bell Telephone Company d/b/a AT&T Texas. The proposed effective date is March 18, 2013. The company holds Service Provider Certificate of Operating Authority Number 60785.

Persons who wish to intervene or comment on this application should notify the commission by March 7, 2013. Requests for further information may be mailed to the Public Utility Commission of Texas, P.O. Box 13326, Austin, Texas 78711-3326 or you may call the commission's Customer Protection Division at (512) 936-7120 or toll-free at (888) 782-8477. Hearing- and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) (800) 735-2989. All comments should reference Docket Number 41173.

TRD-201300370
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 31, 2013

♦ ♦ ♦

Notice of Application to Relinquish a Service Provider Certificate of Operating Authority

On January 31, 2013, Panoptos, LLC (Applicant) filed an application with the Public Utility Commission of Texas (commission) to amend its service provider certificate of operating authority (SPCOA) Number 60674. Applicant seeks to relinquish the certificate.

The Application: Application of Panoptos, LLC to Relinquish its Service Provider Certificate of Operating Authority, Docket Number 41177.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas, 78711-3326 or by phone at (512) 936-7120 or toll-free at 1-888-782-8477 no later than February 22, 2013. Hearing- and speech-im-

paired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll-free at 1-800-735-2989. All comments should reference Docket Number 41177.

TRD-201300431
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: February 1, 2013

♦ ♦ ♦

Notice of Intent to Implement a Minor Rate Change Pursuant to P.U.C. Substantive Rule §26.171

Notice is given to the public of an application filed with the Public Utility Commission of Texas (commission) on February 4, 2013, for approval of a minor rate change pursuant to P.U.C. Substantive Rule §26.171.

Tariff Control Title and Number: Tariff Filing of Santa Rosa Telephone Cooperative, Inc. to Implement a Minor Rate Change Pursuant to Substantive Rule §26.171, Tariff Control Number 41185.

The Application: On February 4, 2013, Santa Rosa Telephone Cooperative Inc. (Santa Rosa or applicant) filed an application for revisions to its Local Exchange Tariff to increase the rates of the Access Line. Santa Rosa proposes an effective date of March 1, 2013. The estimated annual revenue increase recognized by the applicant is $33,752 of its gross annual intrastate revenues. Santa Rosa has 1,637 access lines (residence and business) in service in the state of Texas.

If the commission receives a complaint(s) relating to this application signed by 5% of the affected local service customers to which this application applies by March 4, 2013, the application will be docketed. The 5% limitation will be calculated based upon the total number of customers of record as of the calendar month preceding the commission's receipt of the complaint(s).

Persons wishing to comment on this application should contact the Public Utility Commission of Texas by March 4, 2013. Requests to intervene should be filed with the commission's Filing Clerk at P.O. Box 13326, Austin, Texas 78711-3326 or you may call the commission at (512) 936-7120 or toll-free 1-800-735-2989. Hearing- and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136. All correspondence should refer to Tariff Control Number 41185.

TRD-201300470
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: February 5, 2013

♦ ♦ ♦

Texas Department of Transportation

Aviation Division - Request for Qualifications for Professional Architectural/Engineering Services

The City of Mineral Wells, through its agent the Texas Department of Transportation (TxDOT), intends to engage an aviation professional engineering firm for services pursuant to Government Code, Chapter 2254, Subchapter A. TxDOT Aviation Division will solicit and receive qualifications for professional aviation engineering design services described below.

The following is a listing of proposed projects at the Mineral Wells Airport during the course of the next five years through multiple grants.

Current Project: City of Mineral Wells. TxDOT CSJ No.: 1302MNWLS. Scope: Provide engineering/design services to replace Medium Intensity Runway Lights (MIRLs) on Runway 13-31 and Runway 17-35; and to install PAPI-2 on Runways 17-35.

There is no DBE requirement for the current project. TxDOT Project Manager is Clayton Bridwell.

Future scope work items for engineering/design services within the next five years may include the following:

1. Rehabilitate aprons (5000sy)

2. Rehabilitate terminal apron and southeast apron

3. Rehabilitate and mark Runway 13-31 and Runway 17-35

4. Rehabilitate and mark parallel & connecting taxiways

The City of Mineral Wells reserves the right to determine which of the above scope of services may or may not be awarded to the successful firm and to initiate additional procurement action for any of the services above.

To assist in your qualification statement preparation the criteria, 5010 drawing, project diagram, and most recent Airport Layout Plan are available online at

www.txdot.gov/inside-txdot/division/aviation/projects

by selecting "Mineral Wells Airport." The qualification statement should address a technical approach for the current scope only. Firms shall use page 4, Recent Airport Experience, to list relevant past projects for both current and future scope.

Interested firms shall utilize the latest version of Form AVN-550, titled "Qualifications for Aviation Architectural/Engineering Services." The form may be requested from TxDOT, Aviation Division, 125 E. 11th Street, Austin, Texas 78701-2483, phone number, 1-800-68-PILOT (74568). The form may be emailed by request or downloaded from the TxDOT web site at

www.txdot.gov/inside-txdot/division/aviation/projects.

The form may not be altered in any way. All printing must be in black on white paper, except for the optional illustration page. Firms must carefully follow the instructions provided on each page of the form. Qualifications shall not exceed the number of pages in the AVN-550 template. The AVN-550 consists of eight eight and one half by eleven inch pages of data plus one optional illustration page. The optional illustration page shall be no larger than eleven by seventeen inches and may be folded to an eight and one half by eleven inch size. A prime provider may only submit one AVN-550. If a prime provider submits more than one AVN-550, that provider will be disqualified. AVN-550s shall be stapled but not bound or folded in any other fashion. AVN-550s WILL NOT BE ACCEPTED IN ANY OTHER FORMAT.

ATTENTION: To ensure utilization of the latest version of Form AVN-550, firms are encouraged to download Form AVN-550 from the TxDOT website as addressed above. Utilization of Form AVN-550 from a previous download may not be the exact same format. Form AVN-550 is a PDF Template.

Please note:

Five completed copies of Form AVN-550 **must be received** by TxDOT Aviation Division at 150 East Riverside Drive, 5th Floor, South Tower, Austin, Texas 78704 no later than **March 12, 2013, 4:00 p.m.** Electronic facsimiles or forms sent by email will not be accepted. Please mark the envelope of the forms to the attention of Edie Stimach.

The consultant selection committee will be composed of local government members. The final selection by the committee will generally be

made following the completion of review of AVN-550s. The committee will review all AVN-550s and rate and rank each. The Evaluation Criteria for Engineering Qualifications can be found at

www.txdot.gov/inside-txdot/division/aviation/projects

under the Notice to Consultants link. All firms will be notified and the top rated firm will be contacted to begin fee negotiations. The selection committee does, however, reserve the right to conduct interviews for the top rated firms if the committee deems it necessary. If interviews are conducted, selection will be made following interviews.

Please contact TxDOT Aviation for any technical or procedural questions at 1-800-68-PILOT (74568). For procedural questions, please contact Edie Stimach, Grant Manager. For technical questions, please contact Clayton Bridwell, Project Manager.

TRD-201300371
Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: January 31, 2013

♦ ♦ ♦

Aviation Division - Request for Qualifications for Professional Architectural/Engineering Services

The City of Wills Point, through its agent the Texas Department of Transportation (TxDOT), intends to engage an aviation professional engineering firm for services pursuant to Government Code, Chapter 2254, Subchapter A. TxDOT Aviation Division will solicit and receive qualifications for professional aviation engineering design services described below.

The following is a listing of proposed projects at the Van Zandt County Regional Airport during the course of the next five years through multiple grants.

Current Project: City of Wills Point. TxDOT CSJ No.: 1310WLSPT. Scope: Provide engineering/design services to overlay and mark Runway 17-35; overlay Stub Taxiway; and overlay/repair Apron at the Van Zandt County Regional Airport.

The HUB goal for the current project is 8 percent. The TxDOT Project Manager is Ed Mayle.

Future scope work items for engineering/design services within the next five years may include the following:

1. Widen Runway
2. Rehabilitate turnarounds for Runway 17-35
3. Construct perimeter fence
4. Replace LIRL with MIRL
5. Drainage improvements in the Safety Area
6. Construct T-hangar
7. Construct Terminal Building
8. Construct Auto parking
9. Construct Entrance Road
10. Rehabilitate helicopter landing pad
11. Reconstruct Apron
12. Replace Rotating Beacon

The City of Wills Point reserves the right to determine which of the above scope of services may or may not be awarded to the successful firm and to initiate additional procurement action for any of the services above.

To assist in your qualification statement preparation the criteria, 5010 drawing, project diagram, and most recent Airport Layout Plan are available online at

www.txdot.gov/inside-txdot/division/aviation/projects

by selecting "Van Zandt County Regional Airport." The qualification statement should address a technical approach for the current scope only. Firms shall use page 4, Recent Airport Experience, to list relevant past projects for both current and future scope.

Interested firms shall utilize the latest version of Form AVN-550, titled "Qualifications for Aviation Architectural/Engineering Services." The form may be requested from TxDOT, Aviation Division, 125 E. 11th Street, Austin, Texas 78701-2483, phone number, 1-800-68-PILOT (74568). The form may be emailed by request or downloaded from the TxDOT web site at

www.txdot.gov/inside-txdot/division/aviation/projects.

The form may not be altered in any way. All printing must be in black on white paper, except for the optional illustration page. Firms must carefully follow the instructions provided on each page of the form. Qualifications shall not exceed the number of pages in the AVN-550 template. The AVN-550 consists of eight eight and one half by eleven inch pages of data plus one optional illustration page. The optional illustration page shall be no larger than eleven by seventeen inches and may be folded to an eight and one half by eleven inch size. A prime provider may only submit one AVN-550. If a prime provider submits more than one AVN-550, that provider will be disqualified. AVN-550s shall be stapled but not bound or folded in any other fashion. AVN-550s WILL NOT BE ACCEPTED IN ANY OTHER FORMAT.

ATTENTION: To ensure utilization of the latest version of Form AVN-550, firms are encouraged to download Form AVN-550 from the TxDOT website as addressed above. Utilization of Form AVN-550 from a previous download may not be the exact same format. Form AVN-550 is a PDF Template.

Please note:

SEVEN completed copies of Form AVN-550 **must be received** by TxDOT Aviation Division at 150 East Riverside Drive, 5th Floor, South Tower, Austin, Texas, 78704, no later than **March 5, 2013, 4:00 p.m.** Electronic facsimiles or forms sent by email will not be accepted. Please mark the envelope of the forms to the attention of Beverly Longfellow.

The consultant selection committee will be composed of local government members and one TxDOT Aviation Division staff member. The final selection by the committee will generally be made following the completion of review of AVN-550s. The committee will review all AVN-550s and rate and rank each. The Evaluation Criteria for Engineering Qualifications can be found at

www.txdot.gov/inside-txdot/division/aviation/projects

under the Notice to Consultants link. All firms will be notified and the top rated firm will be contacted to begin fee negotiations. The selection committee does, however, reserve the right to conduct interviews of the top rated firms if the committee deems it necessary. If interviews are conducted, selection will be made following interviews.

Please contact TxDOT Aviation for any technical or procedural questions at 1-800-68-PILOT (74568). For procedural questions, please contact Beverly Longfellow, TxDOT Grant Manager. For technical questions, please contact Ed Mayle, TxDOT Project Manager.

TRD-201300372
Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: January 31, 2013

♦ ♦ ♦

Aviation Division - Request for Qualifications for Professional Architectural/Engineering Services

The City of Navasota, through its agent the Texas Department of Transportation (TxDOT), intends to engage an aviation professional engineering firm for services pursuant to Government Code, Chapter 2254, Subchapter A. TxDOT Aviation Division will solicit and receive qualifications for professional aviation engineering design services described below.

The following is a listing of proposed projects at the Navasota Municipal Airport during the course of the next five years through multiple grants.

Current Project: City of Navasota. TxDOT CSJ No.: 1317NAVAS. Scope: Provide engineering/design services to construct new fuel facility Jet A 100LL; construct Apron for fuel facility; construct Apron for Box Hangars; and construct Access Taxiway for T-Hangar at the Navasota Municipal Airport.

The HUB goal for the current project is 5 percent. The TxDOT Project Manager is Harry Lorton.

Future scope work items for engineering/design services within the next five years may include the following:

1. Rehabilitate Hangar Apron

2. Construct new access road and parking

The City of Navasota reserves the right to determine which of the above scope of services may or may not be awarded to the successful firm and to initiate additional procurement action for any of the services above.

To assist in your qualification statement preparation the criteria, 5010 drawing, project diagram, and most recent Airport Layout Plan are available online at

www.txdot.gov/inside-txdot/division/aviation/projects

by selecting "Navasota Municipal Airport." The qualification statement should address a technical approach for the current scope only. Firms shall use page 4, Recent Airport Experience, to list relevant past projects for both current and future scope.

Interested firms shall utilize the latest version of Form AVN-550, titled "Qualifications for Aviation Architectural/Engineering Services." The form may be requested from TxDOT, Aviation Division, 125 E. 11th Street, Austin, Texas 78701-2483, phone number, 1-800-68-PILOT (74568). The form may be emailed by request or downloaded from the TxDOT web site at

www.txdot.gov/inside-txdot/division/aviation/projects.

The form may not be altered in any way. All printing must be in black on white paper, except for the optional illustration page. Firms must carefully follow the instructions provided on each page of the form. Qualifications shall not exceed the number of pages in the AVN-550 template. The AVN-550 consists of eight eight and one half by eleven inch pages of data plus one optional illustration page. The optional illustration page shall be no larger than eleven by seventeen inches and may be folded to an eight and one half by eleven inch size. A prime provider may only submit one AVN-550. If a prime provider submits more than one AVN-550, that provider will be disqualified. AVN-550s shall be stapled but not bound or folded in any other fashion. AVN-550s WILL NOT BE ACCEPTED IN ANY OTHER FORMAT.

ATTENTION: To ensure utilization of the latest version of Form AVN-550, firms are encouraged to download Form AVN-550 from the TxDOT website as addressed above. Utilization of Form AVN-550 from a previous download may not be the exact same format. Form AVN-550 is a PDF Template.

Please note:

Seven completed copies of Form AVN-550 **must be received** by TxDOT, Aviation Division at 150 East Riverside Drive, 5th Floor, South Tower, Austin, Texas 78704 no later than **March 12, 2013, 4:00 p.m.** Electronic facsimiles or forms sent by email will not be accepted. Please mark the envelope of the forms to the attention of Beverly Longfellow.

The consultant selection committee will be composed of local government members. The final selection by the committee will generally be made following the completion of review of AVN-550s. The committee will review all AVN-550s and rate and rank each. The Evaluation Criteria for Engineering Qualifications can be found at

www.txdot.gov/inside-txdot/division/aviation/projects

under the Notice to Consultants link. All firms will be notified and the top rated firm will be contacted to begin fee negotiations. The selection committee does, however, reserve the right to conduct interviews for the top rated firms if the committee deems it necessary. If interviews are conducted, selection will be made following interviews.

Please contact TxDOT Aviation for any technical or procedural questions at 1-800-68-PILOT (74568). For procedural questions, please contact Beverly Longfellow, Grant Manager. For technical questions, please contact Harry Lorton, Project Manager.

TRD-201300468
Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: February 5, 2013

♦ ♦ ♦

Public Hearing Notice - Unified Transportation Program

The Texas Department of Transportation (department) will hold a public hearing on Tuesday, March 5, 2013, at 10:00 a.m. at 118 East Riverside Drive, First Floor ENV Conference Room, in Austin, Texas, to receive public comments on the proposed updates to the 2013 Unified Transportation Program (UTP).

The UTP is a 10-year program that guides the development and authorizes construction of transportation projects and projects involving aviation, public transportation, and the state's waterways and coastal waters. The Texas Transportation Commission has adopted rules located in Title 43, Texas Administrative Code, Chapter 16, governing the planning and development of transportation projects, which include guidance regarding public involvement related to adoption of the UTP and approval of any updates to the program.

Information regarding the proposed updates to the 2013 UTP will be available at each of the department's district offices, at the department's Transportation Planning and Programming Division offices located in Building 118, Second Floor, 118 East Riverside Drive, Austin, Texas, or (512) 486-5038, and on the department's website at:

http://www.txdot.gov/public_involvement/utp.htm.

Persons wishing to speak at the hearing may register in advance by notifying the Transportation Planning and Programming Division, at (512) 486-5038 not later than Monday, March 4, 2013, or they may register at the hearing location beginning at 9:00 a.m. on the day of the hearing. Speakers will be taken in the order registered. Any interested person may appear and offer comments or testimony, either orally or in writing; however, questioning of witnesses will be reserved exclusively to the presiding authority as may be necessary to ensure a complete record. While any persons with pertinent comments or testimony will be granted an opportunity to present them during the course of the hearing, the presiding authority reserves the right to restrict testimony in terms of time or repetitive content. Groups, organizations, or associations should be represented by only one speaker. Speakers are requested to refrain from repeating previously presented testimony. Persons with disabilities who have special communication or accommodation needs or who plan to attend the hearing may contact the Transportation Planning and Programming Division, at 118 East Riverside Drive Austin, Texas 78704-1205, (512) 486-5038. Requests should be made no later than three days prior to the hearing. Every reasonable effort will be made to accommodate the needs.

Interested parties who are unable to attend the hearing may submit comments regarding the updates to the 2013 UTP to Marc D. Williams, Director of Planning, P.O. Box 149217, Austin, Texas 78714-9217. Interested parties may also submit comments regarding the updates to the 2013 UTP by phone at (800) 687-8108. In order to be considered, all comments must be received at the Transportation Planning and Programming office by 4:00 p.m. on Monday, March 18, 2013.

TRD-201300467
Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: February 5, 2013

♦ ♦ ♦

Request for Proposal - Private Consultant Services

The Texas Department of Transportation (department) announces a Request for Proposal (RFP) for private consultant services pursuant to Government Code, Chapter 2254, Subchapter B. The term of the contract will be from project initiation to March 31, 2015. The department will administer the contract. The RFP will be released on February 15, 2013, and is contingent on the finding of necessity from the Governor's Office.

Purpose: The department is seeking a firm to provide advice, assistance, and support related to the department's management of an enterprise resource planning (ERP) system integration project including: risk identification and mitigation; quality assurance; identification, management, and execution of organizational change management services; strategic public relations services; and direct support to the ERP program manager and staff. The work will involve (1) identifying risks related to the project, their specific sources and applicable mitigation methods; (2) providing a report or presentation regarding risk including, among other things, a strategy analysis addressing key risks; (3) providing project quality assurance (QA) including the developing, documenting, presenting, and adjusting project performance matrix, measures, and measurement methodology; (4) communicating and escalating QA issues; (5) managing organizational change by identifying key change areas, providing the best strategy and an action plan to address specific situations, and monitoring change during the process; and (6) providing public relations, both external and internal, by managing project image, communicating project strategy message, and providing target communications.

Eligible Applicants: Eligible applicants include, but are not limited to, organizations that provide private consulting services.

Program Goal: To obtain independent and specialized advice, assistance, and support related to risk management, quality assurance, organizational change management, and public relations that will enable the in-house project management by the department of a systems integration contract to deploy an ERP solution to design and implement new business processes that will allow the department to retire legacy applications and migrate to the Finance and HR modules of PeopleSoft.

Review and Award Criteria: Each application will first be screened for completeness and timeliness. Proposals that are deemed incomplete or arrive after the deadline will not be reviewed. A team of reviewers from the department will evaluate the proposals as to the private consultant's competence, knowledge, and qualifications and as to the reasonableness of the proposed fee for the services. The criteria and review process are further described in the RFP.

Deadlines: The department must receive proposals prepared according to instructions in the RFP package on or before March 1, 2013 at 3:00 p.m.

To Obtain a Copy of the RFP: Requests for a copy of the RFP should be submitted to Janice Mullenix, 125 East 11th Street, Austin, Texas 78701-2483, email: Janice.mullenix@txdot.gov, telephone number (512) 416-4620, and fax (512) 416-4621. Copies will also be available on the Electronic State Business Daily at http://esbd.cpa.state.tx.us/.

TRD-201300469
Joanne Wright
General Counsel
Texas Department of Transportation
Filed: February 5, 2013

♦ ♦ ♦

Request for Proposal - Professional Services

The Texas Department of Transportation (department) announces a Request for Proposal (RFP) for professional services pursuant to Government Code, Chapter 2254, Subchapter A. The term of the contract will be from project initiation to August 31, 2013. The department will administer the contract. The RFP will be released on February 15, 2013.

Purpose: The department is seeking assistance to (1) perform and document policies and procedures for performing an entity-wide risk assessment for the fiscal year pertaining to financial reporting; (2) identify key internal controls that provide reasonable assurance against material misstatement and provide tools, techniques, or recommendations to reduce risks; and (3) integration of risk assessment into existing spirit of SOX internal control annual processes and procedures.

Eligible Applicants: Eligible applicants include, but are not limited to, regionally recognized qualified Certified Public Accounting (CPA) firms.

Program Goal: The completion of a report which includes an ongoing process of policies and procedures relating to risk assessments and internal controls that will provide greater responsiveness and accountability for department actions.

Review and Award Criteria: Each application will first be screened for completeness and timeliness. Proposals that are deemed incomplete or arrive after the deadline will not be reviewed. A team of reviewers from the department will evaluate the proposals as to the accounting firm's competence, knowledge, and qualifications and as to the reasonableness of the proposed fee for the services. The criteria and review process are further described in the RFP.

Deadlines: The department must receive proposals prepared according to instructions in the RFP package on or before March 15, 2013 at 3:00 p.m.

To Obtain a Copy of the RFP: Requests for a copy of the RFP should be submitted to Amanda Landry, Finance Division, Texas Department of Transportation, 150 East Riverside Drive, Austin, Texas 78704, email: Amanda.Landry@txdot.gov, telephone number (512) 486-5614 and fax (512) 486-5390. Copies will also be available on the Electronic State Business Daily at (http://esbd.cpa.state.tx.us/).

TRD-201300490
Angie Parker
Associate General Counsel
Texas Department of Transportation
Filed: February 6, 2013

♦ ♦ ♦

Request for Qualifications

Pursuant to the authority granted under Transportation Code, Chapter 223 (enabling legislation), the Texas Department of Transportation (department) may enter into public-private partnership agreements, also known as comprehensive development agreements, for the design, development, construction, financing, maintenance, and operation of a toll project on the state highway system. The enabling legislation authorizes private involvement in toll projects and provides a process for the department to solicit proposals for such projects. Transportation Code, §223.203 prescribes requirements for issuance of a request for qualifications and requires the department to publish a notice in the *Texas Register* if the department decides to issue a request for qualifications for a project. The Texas Transportation Commission (commission) has promulgated rules located at Title 43, Texas Administrative Code, §§27.1 - 27.10 (the rules), governing the submission and processing of qualifications submittals, and providing for publication of notice that the department is requesting qualifications submittals, and setting forth the basic criteria for professional experience, technical competence, and capability to complete a proposed project, and such other information the department considers relevant or necessary in the request for qualifications. The commission has authorized the issuance of a request for qualifications to develop, design, construct, finance, maintain, and operate tolled managed lanes, general purpose lanes, and associated facilities along State Highway 183 from State Highway 121 to Interstate Highway 35E and any additional connecting facilities that are necessary for connectivity and financing purposes (project), through a public-private partnership agreement (P3A).

On January 31, 2013, in Minute Order 113427, the commission authorized the department to commence the procurement process for the project under the enabling legislation. This notice represents the next step in the process.

Through this notice, the department is seeking qualifications submittals (QS) from teams interested in entering into a toll concession P3A in response to a request for qualifications (RFQ). The department intends to evaluate any QS received and may request submission of detailed proposals, potentially leading to negotiation, award, and execution of a P3A. The department will accept for consideration any QS received in accordance with the rules and the RFQ on or before the deadline in this notice. The department anticipates issuing the RFQ, receiving and analyzing the QSs, developing a shortlist of proposing entities or consortia, and issuing a request for detailed proposals (RFP) to the shortlisted entities. After review and a best value evaluation of the responses to the RFP, the department may negotiate and enter into a P3A for the project.

RFQ Evaluation Criteria. QSs will be evaluated by the department for shortlisting purposes using the following general criteria: technical qualifications and capability, statement of technical approach, project finance qualifications and capability, conceptual project financing discussion, and safety qualifications. The specific criteria under the foregoing categories will be identified in the RFQ, as will the relative weighting of the criteria.

Release of RFQ and Due Date. The department currently anticipates that the RFQ will be available on February 15, 2013. Copies of the RFQ will be available at the department's Dallas District office located at 4777 E. Highway 80, Mesquite, Texas 75150-6643 and on the following website:

www.txdot.gov/government/partnerships/current-cda/sh183/183-rfq.

QSs will be due at 12:00 p.m. Central Time on May 15, 2013 at the address specified in the RFQ.

TRD-201300489
Angie Parker
Associate General Counsel
Texas Department of Transportation
Filed: February 6, 2013

♦ ♦ ♦

Texas Water Development Board

Request for Applications for Agricultural Water Conservation Grants-Fiscal Year 2013

Request for Applications

The Texas Water Development Board (TWDB) solicits Request for Applications (RFAs) for the state fiscal year 2013. The total amount of the grants to be awarded by the TWDB shall not exceed $600,000 from the Agricultural Water Conservation Fund. The rules governing the Agricultural Water Conservation Fund (31 Texas Administrative Code, Chapter 367) and application instructions are available upon request from the TWDB.

Summary of the RFA

Solicitation Date (Opening): Date published in the *Texas Register*

Due Date (Closing): 12:00 p.m., Wednesday, April 17, 2013

Anticipated Award Date: June 20, 2013

Estimated Total Funding: $600,000

Eligible applicants: Political Subdivisions, State Agencies, and State Institutions of Higher Learning

Contact: Cameron Turner, Agricultural Water Conservation Division, Texas Water Development Board, P.O. Box 13231, Austin, Texas 78711-3231, Phone: (512) 936-6090, E-mail: cameron.turner@twdb.texas.gov

Agricultural Water Conservation Grant Categories:

Applicants must be in response to one of the following three categories:

1. Agricultural irrigation water use measurement equipment

Individual applications in this category are limited to $100,000 in TWDB grant funds. Applications must identify an agricultural water conservation strategy from their applicable most recent regional water plan and/or the 2012 State Water Plan. Entities that received TWDB grants funds for irrigation metering projects in the past two years are not eligible for a 2013 metering grant in this category. The intent is to attract new entities to participate in the TWDB voluntary irrigation metering program and/or bring back those entities that previously participated but are no longer involved in the program.

Grants may include up to 100 percent of the costs associated with the purchase and installation of agricultural irrigation measurement devices, portable flow meters, telemetry, and weather monitoring accessories. Applicants will be responsible for all other costs including, but not limited to, maintenance, data collection, reporting services, and all other expenses for the duration of the contract. Water use data must be reported annually for each piece of equipment installed for a period of at least five full calendar year irrigation seasons following installation. These annual data reports are to include irrigated acreage, crop type, irrigation rate (inches per acre), total water use, county name, latitude/longitude coordinates, and annual rainfall totals by county and/or by rain gauge location. Annual water savings estimates and an explanation of the water savings calculation methodology resulting from use of the equipment must be reported along with the five-plus years of water use data.

2. Agricultural irrigation system improvements

Individual applications in this category are limited to a maximum of $250,000 in TWDB grant funds (plus required local match). Applications must identify an agricultural water conservation strategy from their applicable most recent regional water plan and/or the 2012 State Water Plan. Eligible applications must include at least a 50 percent local cost-share for all project expenses. Priority may be given to projects with the highest local cost-share percentages and/or leveraging of other sources of funding.

Projects to improve irrigation water deliveries and application efficiency will be considered on a cost-share basis. Potential scope of work for projects considered in this category includes:

Replacement and/or upgrades of outdated systems with newer more efficient systems, such as:

Canal to pipeline conversions; Canal lining and other necessary maintenance to water distribution systems; Assistance [provided from state agency or political subdivision] to farmers to convert to higher efficiency, water conserving irrigation systems. For example, converting from flood irrigation to center pivot, drip, or other appropriate water conserving irrigation systems.

Implementation of centralized control systems, such as:

Supervisory Control and Data Acquisition (SCADA) technology; Telemetry; Automated gates

Other proven, innovative, cost-effective technologies and equipment that will improve irrigation water deliveries and water use efficiency leading to realization of actual water savings.

Applicants are required to report on a quarterly basis during the implementation phase, provide three annual water savings reports following implementation, and provide a draft and final report upon completion of the three full years of water savings reporting.

3. Feasibility and Assessment Study of Remote Sensing Technologies to Assist with Estimating Irrigation Water Use

Individual applications in this category are limited to $200,000 in TWDB grant funds (plus local match). Priority may be given to projects with the highest local cost-share percentages and/or leveraging of other sources of funding. Projects considered for this category must include a comprehensive feasibility study of remote sensing technologies capable of estimating precipitation and evapotranspiration in order to develop estimates of irrigation water use. Projects will be selected based on the proficiency of the primary applicant and their team members experience in the use of remote sensing technologies for successfully and accurately estimating agricultural water use.

Scope of work for projects considered for this category should include an assessment of applicable methods and models currently employed in Texas, the Unites States, and worldwide. Work products developed would involve a comprehensive summary of all remote sensing platforms and applicable data sets (both public and non-public domain) including, but not limited to, precipitation estimates, evapotranspiration estimates, soil moisture measurements, etc. Summary of each technology should include at a minimum:

Costs: Software/hardware purchases; Staff time and development or training required to utilize identified methods; Public domain versus non-public domain datasets. Technical experience and expertise necessary to pursue applicable technologies; Accuracy assessment of each technology; Applicability to all climate regions and cropping practices in Texas; Logistics of availability and/or collection of ground truth data; Time scale for implementation and annual product schedule

The end goal of selected projects in this category is to identify tools with the ability to improve upon the current estimation methodology used by TWDB in developing annual irrigation water use estimates.

Selected applicant(s) will be required to report on a quarterly basis and provide a draft and final report upon completion of the study.

Grant Amount

Up to $600,000 has been initially authorized for fiscal year 2013 assistance for agricultural water conservation grants from the TWDB's Agricultural Water Conservation Fund (Ag Fund). Funds will be awarded through a statewide competitive grants process. TWDB may fund single- and multi-year projects. Applicants may submit more than one application; however, individual applicants are only eligible to receive fiscal year 2013 agricultural water conservation grants not to exceed a total of $250,000. *In an effort to maximize the direct benefits gained from the grant projects, and in order to extend the life of the agricultural water conservation grants program, TWDB is no longer allowing overhead as an allowable expense category eligible for reimbursement through TWDB Agricultural Grant Funding.* All proposals will be evaluated based upon the specific criteria set forth in this solicitation.

Description of Applicant Criteria

The applicable scope of work, schedule, and contract amount will be negotiated after the TWDB selects the most qualified applicants and/or the desired projects for funding. Failure to arrive at mutually agreeable terms of a contract with the most qualified applicant shall constitute a rejection of the Board's offer and may result in subsequent negotiations with the next most qualified applicant. The TWDB reserves the right to reject any or all applications if staff determines that the application(s) does not adequately meet the required criteria or if the funding available is less than the requested funding.

Application instructions are available upon request from Cameron Turner at (512) 936-6090 or cameron.turner@twdb.texas.gov, or online at http://www.twdb.texas.gov/.

Deadline for Submission of Applications

Six double-sided, double-spaced copies on recycled paper and one digital copy (CD) of a completed application must be filed with the TWDB on or before 12:00 p.m. on Wednesday, April 17, 2013. Applications can be directed either in person to David Carter, Texas Water Development Board, Stephen F. Austin Building, Room 610D, 1700 North Congress Avenue, Austin, Texas, 78701; or by mail to David Carter, Texas Water Development Board, P.O. Box 13231-Capitol Station, Austin, Texas 78711-3231.

TRD-201300442

Kenneth Petersen
General Counsel
Texas Water Development Board
Filed: February 4, 2013

♦ ♦ ♦

Workforce Solutions Capital Area

Public Notice

The Workforce Solutions Capital Area Workforce Board is soliciting proposals from qualified vendors to provide an on-line, web-based work readiness training and certification system.

A copy of the Request for Proposals (RFP) may be obtained from the Board beginning at 10:00 a.m., February 4, 2013 at 6505 Airport Boulevard, Suite 101E, Austin, Texas 78752 or by email request to peter.brodeur@wfscapitalarea.com. The RFP may also be downloaded from www.wfscapitalarea.com. All proposals must be received on or before 12:00 p.m., March 4, 2013.

TRD-201300391
Alan D. Miller
Executive Director
Workforce Solutions Capital Area
Filed: February 1, 2013

♦ ♦ ♦

How to Use the Texas Register

Information Available: The 14 sections of the ***Texas Register*** represent various facets of state government. Documents contained within them include:

Governor - Appointments, executive orders, and proclamations.

Attorney General - summaries of requests for opinions, opinions, and open records decisions.

Secretary of State - opinions based on the election laws.

Texas Ethics Commission - summaries of requests for opinions and opinions.

Emergency Rules- sections adopted by state agencies on an emergency basis.

Proposed Rules - sections proposed for adoption.

Withdrawn Rules - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.

Adopted Rules - sections adopted following public comment period.

Texas Department of Insurance Exempt Filings - notices of actions taken by the Texas Department of Insurance pursuant to Chapter 5, Subchapter L of the Insurance Code.

Texas Department of Banking - opinions and exempt rules filed by the Texas Department of Banking.

Tables and Graphics - graphic material from the proposed, emergency and adopted sections.

Transferred Rules- notice that the Legislature has transferred rules within the *Texas Administrative Code* from one state agency to another, or directed the Secretary of State to remove the rules of an abolished agency.

In Addition - miscellaneous information required to be published by statute or provided as a public service.

Review of Agency Rules - notices of state agency rules review.

Specific explanation on the contents of each section can be found on the beginning page of the section. The division also publishes cumulative quarterly and annual indexes to aid in researching material published.

How to Cite: Material published in the ***Texas Register*** is referenced by citing the volume in which the document appears, the words "TexReg" and the beginning page number on which that document was published. For example, a document published on page 2402 of Volume 36 (2011) is cited as follows: 36 TexReg 2402.

In order that readers may cite material more easily, page numbers are now written as citations. Example: on page 2 in the lower-left hand corner of the page, would be written "36 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 36 TexReg 3."

How to Research: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the ***Texas Register*** office, Room 245, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using ***Texas Register*** indexes, the ***Texas Administrative Code***, section numbers, or TRD number.

Both the ***Texas Register*** and the ***Texas Administrative Code*** are available online at: http://www.sos.state.tx.us. The ***Register*** is available in an .html version as well as a .pdf (portable document format) version through the internet. For website information, call the Texas Register at (512) 463-5561.

Texas Administrative Code

The ***Texas Administrative Code (TAC***) is the compilation of all final state agency rules published in the ***Texas Register***. Following its effective date, a rule is entered into the ***Texas Administrative Code***. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the ***TAC***.

The ***TAC*** volumes are arranged into Titles and Parts (using Arabic numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency.

The complete TAC is available through the Secretary of State's website at http://www.sos.state.tx.us/tac.

The following companies also provide complete copies of the TAC: Lexis-Nexis (800-356-6548), and West Publishing Company (800-328-9352).

The Titles of the ***TAC***, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

How to Cite: Under the ***TAC*** scheme, each section is designated by a ***TAC*** number. For example in the citation 1 TAC §27.15: 1 indicates the title under which the agency appears in the ***Texas Administrative Code***; ***TAC*** stands for the ***Texas Administrative Code***; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to update: To find out if a rule has changed since the publication of the current supplement to the ***Texas Administrative Code***, please look at the ***Index of Rules***. The *Index of Rules* is published cumulatively in the blue-cover quarterly indexes to the ***Texas Register***. If a rule has changed during the time period covered by the table, the rule's ***TAC*** number will be printed with the ***Texas Register*** page number and a notation indicating the type of filing (emergency, proposed, withdrawn, or adopted) as shown in the following example.

TITLE 1. ADMINISTRATION
Part 4. Office of the Secretary of State
Chapter 91. Texas Register
40 TAC §3.704.....950 *(P)*